IRIS ORBUCH, MD

PERSONAL INFORMATION

Last Name: ______________________ First Name: ______________________ M.I.________
Date of Birth: ______________________ SS# ______________________
Mailing Address ______________________ Apt ______________
City: ______________________ State: ______________ Zip: ______________
Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________
Email Address: ______________________
(Please check which number is preferred for contact)

PREFERRED PHARMACY

Name: ______________________ Phone: ______________________
Address ______________________

STATE ID # ______________________

Emergency Contact: ______________________ Phone: ______________________

Employer's Name: ______________________ Occupation: ______________________
Employer's Address: ______________________
Referring M.D. ______________________ Phone: ______________________

SPOUSE/PARTNER INFORMATION

Spouse/Partner's name: ______________________
Spouse/Partner's D.O.B. ______________________ SS# ______________________
Insurance: ______________________ ID# ______________________
Employer's Name: ______________________ Address: ______________________

INSURANCE INFORMATION:

Primary Carrier Insurance Company to bill ______________________
Insured Name: ______________________ Insured D.O.B. ______________________
Insurance Carrier: ______________________

I verify the accuracy of the above information and authorize the release of the information necessary to process any claims. I also request payment claim directly to my physician for service rendered. In the event of the receipt of payments from my insurance carrier, I will forward all funds to Dr. Iris Orbuch.

Date: ______________________ Patient Signature/Parent of Guardian: ______________________

I understand that all medical cost incurred by me are my responsibility, including any charges my insurance fails to pay. I also understand that I am responsible for any collection and/or legal efforts that may be necessary on my account. In the event that my account becomes delinquent and my past due account is forwarded out to collection (be it a collection agency or law firm). I agree to be responsible for the collection fee we (provider of services) are charged not to exceed 33%

Date: ______________________ Patient Signature/Parent of Guardian: ______________________