Dr. Valentina Gherghina
Dr. Daniela Capota

Medical Associates of The Palm Beaches
10151 Enterprise Center Blvd., Suite 204
Boynton Beach, FL 33437

PATIENT REGISTRATION

Patient Information **Date: _____**

Patient Name (Last/First/MI): _____

Date of Birth: _____ Social Security Number: _____-_____-_____ Sex: M ___ F ___

Marital Status: Single ___ Married ___ Widowed ___ Divorced ___ Separated ___

Florida Address:_____City_____State____Zip_____

Out-of-State Address:_____City_____State____Zip_____

Home Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____ Work Phone: (_____)_____-_____

E-mail Address: _____ Receive e-mail communication? Y ___ N ___

Employer Information

Employer Name: _____ Employer Phone Number: (_____)_____-_____

Responsible Party (Guarantor) (*If different from patient)*

Name: _____ Relationship: _____ Date of Birth: _____

Home Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____ Work Phone: (_____)_____-_____

Address:_____City_____State____Zip_____

Emergency Contact

Name: _____ Relationship: _____Phone: (_____)_____-_____

Address:_____City_____State____Zip_____

How did you hear about our Practice? _____

Insurance (*Fill out or provide the insurance card to copy*)

Primary Insurance

Plan Name: _____ I.D. Number: _____ Group Number: _____

Policy Holder: _____ Policy Holder's Date of Birth: _____

Policy Holder's Social Security Number: _____-_____-_____

Secondary Insurance

Plan Name: _____ I.D. Number: _____ Group Number: _____

Policy Holder: _____ Policy Holder's Date of Birth: _____

Policy Holder's Social Security Number: _____-_____-_____

Assignment & Release

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Medical Associates of The Palm Beaches or Valentina Gherghina, M.D., P.A. all insurance benefits for services rendered. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that I will be responsible for any fees or interest should my account become past due, if my account should be turned over to a collection agency for handling possible actions by agency including additional fees credit reporting and legal pursuit.

Responsible Party Signature: _____ Relationship: _____ Date: _____