Neurology & Psychiatry
IDAN SHARON, M.D.

REGISTRATION FORM

Date_____

1) PATIENT INFORMATION:

Last Name_____First Name_____
Street Address_____
City_____State_____Zip_____
Home Phone_____Work_____
SS#_____Date Of Birth_____
Marital Status_____Sex_____
Employment/Occupation_____Employer_____
Referring Doctor_____
Emergency contact:_____Relationship_____
Phone#_____

2) INSURANCE INFORMATION:

Primary Insurance_____ID #_____
Group#_____Phone#_____Copay Amount_____
Insured 's name_____Date Of Birth_____
SS#_____Relationship to patient_____
Address_____
City_____State_____Zip_____Phone#_____

Secondary Insurance_____ID#_____
Group#_____Phone#_____

3) INFORMATION AND ASSIGNMENT OF BENEFITS:

[] I hereby authorize Idan Sharon, M.D. to apply on my behalf for covered services rendered by him, or by his order. I request that payment from my insurance company be made directly to Dr. Sharon (or to the party who accepts assignment).
[] I authorize Idan Sharon, M.D. to release medical information regarding my care to process payments.
[] I authorize Dr. Sharon to use medications off label to treat and alleviate symptoms of my illness.

Date_____Signature_____