Todd A. Schneiderman, MD FACS

Name: _____ Date of Birth: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Email: _____

Cell Phone #: _____ Marital Status: Married: ___ Single: ___ Widowed: ___ Divorced: ___

Occupation: _____

Employer's Name: _____ Work Phone #: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Social Security #: ___-___-___ Emergency Phone: _____

How did you learn about our practice: _____

Pharmacy: _____

Parent / Guardian / Spouse Information

Name: _____ Date of Birth: _____

Home Address: _____ (If different) City: _____ State: _____ Zip: _____

Home Phone: _____ (If different) Work Phone #: _____ SS#: ___-___-___

Employer's Name: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Primary Insurance:

Name of Insurance: _____ ID#: _____

Insured's Name: _____ Insured Date of Birth: _____ Group #: _____

Secondary Insurance:

Name of Insurance: _____ ID#: _____

Insured's Name: _____ Group #: _____

Medicare Lifetime Signature on File:

I request that payment of authorized Medicare benefits be made on my behalf to Todd A Schneiderman, MD, FACS, for any services furnished me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing administration and its agents any information to determine these benefits payable for related services.

_____ _____

Patient Signature Date

Private Insurance Authorization for Assignment of Benefits/Information Release:

I, the undersigned authorize payment of medical benefits to Todd A. Schneiderman, MD, FACS, for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

_____ _____

Patient, Parent or Guardian Signature (if child is under 18 years old) Date