

**David Herson MD PA**  
**CONFIDENTIAL REGISTRATION INFORMATION**

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient Name \_\_\_\_\_  
First Middle Initial Last

Address \_\_\_\_\_  
\_\_\_\_\_  
City State Zip

HOME PHONE: ( ) \_\_\_\_\_ - \_\_\_\_\_ CELL PHONE ( ) \_\_\_\_\_ - \_\_\_\_\_

Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ ( ) Male ( ) Female Marital Status \_\_\_\_\_

Employed ( ) Yes ( ) No Occupation \_\_\_\_\_

Employer's Name \_\_\_\_\_

Address \_\_\_\_\_

Work Phone ( ) \_\_\_\_\_

Name of person to contact in case of emergency: \_\_\_\_\_ phone ( ) \_\_\_\_\_ - \_\_\_\_\_

Is this illness or injury the result of an Auto Accident? ( ) Yes ( ) No Date of Injury/Accident \_\_\_\_\_

State in which accident occurred \_\_\_\_\_

**WHO IS RESPONSIBLE FOR PAYMENT: Name** \_\_\_\_\_

Address \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Occupation \_\_\_\_\_ Employer's Name \_\_\_\_\_

Work phone ( ) \_\_\_\_\_ - \_\_\_\_\_ Home phone ( ) \_\_\_\_\_ - \_\_\_\_\_ Relationship \_\_\_\_\_

**COMPLETE IF MARRIED:** (mark same as above if need) Spouse name \_\_\_\_\_

Spouse Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Spouse Occupation \_\_\_\_\_

Spouse Employer \_\_\_\_\_ Address \_\_\_\_\_

Employer Phone ( ) \_\_\_\_\_ - \_\_\_\_\_

**PRIMARY INSURANCE COMPANY** \_\_\_\_\_

ADDRESS OF INSURANCE. COMPANY. \_\_\_\_\_

POLICYHOLDER: \_\_\_\_\_ Patient relationship to policy holder ( ) Self ( ) Spouse

POLICY NUMBER OF INSURED: \_\_\_\_\_

GROUP NAME \_\_\_\_\_

GROUP NUMBER \_\_\_\_\_

Does your insurance company require preauthorization? ( ) Yes ( ) No

Phone number for preauthorization \_\_\_\_\_

**SECONDARY INSURANCE COMPANY** \_\_\_\_\_

ADDRESS \_\_\_\_\_

POLICYHOLDER: \_\_\_\_\_ Patient relationship to policy holder ( ) Self ( ) Spouse

POLICY NUMBER OF INSURED: \_\_\_\_\_

GROUP NAME \_\_\_\_\_

GROUP NUMBER \_\_\_\_\_

Does your insurance company require preauthorization? ( ) Yes ( ) No

Phone number for preauthorization \_\_\_\_\_

**Referring Physician** \_\_\_\_\_ Phone ( ) \_\_\_\_\_ - \_\_\_\_\_

Address \_\_\_\_\_

**Primary Care Physician** \_\_\_\_\_ Phone ( ) \_\_\_\_\_ - \_\_\_\_\_

Address \_\_\_\_\_

**Should any other physicians receive copies of your consultation and progress reports? ( ) No ( ) Yes**  
**If so, please write the name of the physician, specialty, address and phone number on the back of this sheet.**