REGISTRATION FORM – NICK WEISS, M.D. PLLC

Patient Name:_____ DOB:_____

Parent/Guarantor Name(s):_____

Address:_____

City:_____ State:_____ Zip:_____

Key Phone Numbers:

_____ Messages ok? ◯ Yes ◯ No

_____ Messages ok? ◯ Yes ◯ No

Email:_____

Emergency Contact:_____ Relationship:_____

Insurance:_____

Subscriber:_____ Relation to Subscriber:_____

Group #:_____ ID#_____

Employer of Subscriber:_____

Primary Care Provider:_____

PCP Phone Number and Address:_____

Pharmacy:_____

Pharmacy Phone Number and Address:_____

Referred to Practice by Whom:_____

I hereby acknowledge and accept financial responsibility for charges incurred by the above named patient while receiving care at Nick Weiss, M.D., PLLC.

Signature:_____ Date:_____

I hereby authorize Dr. Nick Weiss to provide medical information gained through history, physical, progress notes and lab findings to my insurance company to aid in processing any future insurance claims.

Signature:_____ Date:_____