Patient Registration Form (please print) **Suffolk Rehabilitation Medicine, PLLC. Mike M. Pappas, D.O.**

Last Name_____ First Name _____MI_____

Street Address_____Apt#_____City_____State_____Zip_____

Home Phone ( ) _____ Cell Phone ( ) _____

Emergency Contact_____ Relationship_____ Phone ( ) _____

Social Security# _____Date of Birth____/____/____ Sex □M □ F

Reason for initial visit_____

Name of Referring Doctor/Person_____ Address _____

City_____ State_____ Zip_____ Ref Doctor Phone # _____

Family Physician_____ Phone # _____

Name of Employer_____Address_____

City_____ _____State _____ Zip _____Phone# _____

May we contact you at work □Yes □No

Primary Insurance Name _____Phone # _____

Policy # _____Group # _____Co-pay amt$ _____ Effective date ____/____/___

Name of Insured _____ Relationship to patient □Self □Spouse □Child □other

Insured Date of Birth _____/_____/_____ Insured Social Security #_____

Secondary Insurance Name _____Phone # _____

Policy # _____Group # _____Co-pay amt$ _____ Effective date ____/____/___

Name of Insured _____ Relationship to patient □Self □Spouse □Child □other

Insured Date of Birth ____/_____/_____ Insured Social Security#_____

□Workmans Compensation □No Fault Claim # _____

Attorney Name/Address_____

Attorney Phone #_____Fax# _____ Contact Person _____

1) I authorize the release of my personal information necessary to process my insurance claim(s) to Suffolk Rehabilitation Medicine, PLLC
2) I authorize and request payment of medical benefits directly to my physician, Dr. Mike M. Pappas, Suffolk Rehabilitation Medicine, PLLC
3) I agree that a photocopy of this form may be used as the original
4) I agree to pay all charges not covered by my insurance carrier. These charges include but are not limited to deductible co-payments, co-insurance and non-covered service.

_____ _____

Patient/Authorized Signature ***Date***