Patient Registration Form

Stacie Castle, MS, RD, CDN
(516) 652-2747

Patient Name _____ SSN _____

Street Address _____ Date of Birth _____Age_____

Town/City _____ State _____ ZIP _____ Gender M F

Home Phone _____ Work Phone _____ Mobile _____

A message can be left on my_____ phone. E-Mail _____

Occupation _____ Employer's Phone _____

Marital Status _____ Spouse's Name _____ Phone # _____

Referring Doctor _____ Phone # _____

Address _____ City _____ State_____ Zip_____

Employer's Name _____ Phone # _____

Spouse (or Parent) Employer's Name _____ Phone # _____

Primary Insurance Company Name _____ ID # _____

Telephone # on back of Card _____

Do you have any other Insurance? YES NO (if yes, list name and ID #) _____

Insured's Name _____ Date of Birth _____ Relationship to patient _____

Address (if different) _____

Privacy Consent, Authorization for Treatment, Payment and Healthcare Operations

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.
I agree to pay Stacie Castle, MS, RD, CDN in a timely and current manner, any balance of medical charges and expenses such as services not covered by insurance plan, copays and/or deductibles that are the patient's responsibility.
If you require a referral to see a specialist on your plan – **you must present the referral form at the time of visit.**

Medicare B Patients:

"I request that payment of authorized Medicare benefits be made to Stacie Castle, MS , RD, CDN for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits of the payable for related services."

I have received a copy of the most current Notice of Privacy Practices. ***Please Initial*** _____

PATIENT'S (Or Authorized) *SIGNATURE*_____ DATE _____