Comprehensive Medical Care of Danbury

27 Hospital Avenue
Suite 403
Danbury, CT 06810
www.cmcdanbury.com
203-730-2900

Patient Registration

Patient Name:	Patient Date of Birth:	Today's visit date:
Home Address:	City:	State and Zip Code:
Employer:	Occupation:	Marital Status:
Patient Social Security #:	Patient Drivers License #:	Home Phone Number:
Patient Work Phone: ( ) - Patient Cell Phone: ( ) -	Spouses name, if applicable:	Phone Number for spouse: ( ) -
Emergency Contact Name:	Phone Number for Emergency Contact: ( ) -	Address for Emergency Contact:
Billing Name (if different than above)	Billing address (if different than above)	Relationship to patient
Primary Health Insurance Company Name:	Address:	Policy Number:
Name of Insurance Holder	Relationship to Patient	Group Number:
Secondary Health Insurance Company Name, if applicable:	Address:	Policy Number:
Email:		

AUTHORIZATION TO PROVIDE MEDICAL HEALTH SERVICES

I authorize my doctor to diagnose, treat and provide me with medical and healthcare services and I further agree to treatment plans.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Dr. Taweh to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical/medical benefits to Dr. Taweh for services rendered by him in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance.

POLICY FOR MISSED APPOINTMENTS

I understand that there will be a "NO SHOW" fee for missed appointments that are not cancelled at least 24 hours in advance($ 25 for regular visit/ $ 50 for physicals/ prolonged service)

MEDICARE/MEDICAID

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request.
I request that payment of authorized benefits be made on my behalf.
A photocopy of the assignments shall be valid as the original.

PATIENT OR PARENT/GUARDIAN NAME:	PATIENT OR PARENT/GUARDIAN SIGNATURE: