DANIEL L CASSIS MD PA
4302 ALTON ROAD SUITE 100 | MIAMI BEACH, FL 33140
Phone: (305) 535-7404 | Fax: (305) 535-7408 | info@drdanielcassis.com | www.drdanielcassis.com

DANIEL L CASSIS M.D., F.A.C.C.

REGISTRATION FORM
(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's Name (Last, First, Middle):	☐ Mr. ☐ Mrs.	☐ Dr. ☐ Ms.	Marital status (circle one): Single / Mar / Div / Sep / Wid

Social Security:	Name of Partner:

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ☐ M ☐ F

Billing Address:		Apartment/Unit:
City:	State:	ZIP Code:

Local Telephone: ( )	Mobile Number: ( )	Fax: ( )

Local/Secondary Address:		Apartment/Unit:
City:	State:	ZIP Code:

Pharmacy Name:	Pharmacy Number: ( )
Email:	Website:
Referring or Primary Physician:	
Phone Number: ( )	Fax: ( )

EMPLOYMENT INFORMATION

Occupation:	Employer:	Employer Phone Number: ( )
Company Address:		

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Primary Insurance Company:	
Policy Number:	Group Number:
Secondary or Supplemental Insurance Company:	
Policy Number:	Group Number:

Initial_____

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EMERGENCY CONTACT	
Name:	
Relationship:	Phone:

CONSENT FOR TREATMENT

I hereby give consent for performance of medical treatment. I consent to examination, diagnosis and general medical care and treatment (including but not limited to physical examinations, administration of medications, the taking of x-rays, blood draws, diagnostic tests, laboratory tests, immunizations, and other screening tests and minor procedures). In addition, I agree to abide by facility regulations designed to enhance the care and safety of patients.

Initials:_____

FINANCIAL POLICIES

I agree to pay for the charges for medical services rendered. I understand that my health insurance may not pay the full amount of the fees charged; I agree to pay for those charges which are not paid by my health insurance. If I have **not** given this facility the correct health information; I may have to pay the fees for my care. If I do not carry health insurance, then I agree to pay the facility for charges, unless other arrangements are made.

I authorize payment of Medicare, Medicaid or other insurance benefits otherwise payable to me for the services provided that are deemed necessary by me or my child's physician(s), directly to this facility and its affiliates, attending and consulting physicians and allied health professionals. Where Medicare and Medicaid benefits are applicable, I certify that the information given by me in applying for payment under Title XVII and XIX of Social Security Act is correct, and request that these payments of authorized benefits be made directly to this facility and its affiliates, attending and consulting physicians and allied health professionals on my behalf.

Initials:_____

RECORD RELEASE AUTHORIZATION

I hereby consent to the release of information to other doctors, staff and healthcare providers who treat me. I also authorize the release of health information to insurance companies or any payer source, for billing purposes. I further give my permission to allow agencies hospital, physicians, insurance companies, adjuster, healthcare providers to review my clinical records, including those representatives from State, Federal and regulatory agencies. I hereby consent to my data being used for research purposes; however I will not be individually identified in any way.

Initials:_____

PERSONAL REPRESENTATIVE(S)

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I hereby give consent to the release of health information to a representative that I so choose for the purpose of requesting health information, medical results, physician consultation and scheduling.

Name:	Relationship:
Name:	Relationship:
Name:	Relationship:
Name:	Relationship:

Initials:_____

PATIENT ACKNOWLEDGEMENT

By signing below I also agree that:

- The Facts given to this facility are correct.
- I have read and understand all the facts stated above.
- I have had the opportunity to ask questions about this information; all my questions have been answered.

Signature of Patient:_____
Date:_____

Print Name:_____

Signature of Legal Guardian:_____
Date:_____

Print Name:_____