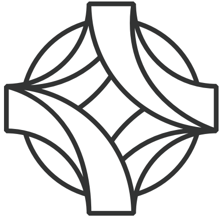

Ana D. Lipson, M.D.

210 First Street North
Winter Haven, FL 33881
Phone: 863-293-4800
Fax: 863-293-4410

PATIENT REGISTRATION PLEASE PRINT CLEARLY AND BRING TO YOUR FIRST APPOINTMENT OR SCAN AND FAX TO: 863-293-4410

PATIENT REGISTRATION FORM

Last Name: ____________________________________First Name: ___________________Middle Initial: _______SS#:________-____-_______

Street Address: ____ Home Phone: ______________

City: ____State: ________________ Zip:_______________ Cell Phone: ________________

Sex: Male ☐ Female ☐ Date of Birth: ____________________ ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ SEPARATED ☐ DIVORCED

How Did You Hear About Us? ☐ Web Site ☐ Phone Book ☐ Referred By A Friend, Who? ____

In Case Of Emergency, Who Should We Notify? Name: ______________________________Relationship:___________Phone:_______________

EMPLOYEE INFORMATION

Patient Employer: ____Business Phone: _______________________________

Street Address: ____City:__________________State:______________Zip:_____________

SPOUSE / RESPONSIBLE PARTY INFORMATION

Last Name: ____________________________________First Name: ___________________Middle Initial: _______SS#:_______-____-________

Person Responsible for Account: ____

Relationship to Patient: _____________________Date of Birth: _________________ _____ Social Security Number: ________-_____-________

Street Address: ____ Work Phone: _______________

City: ____State: _________________ Zip: ______________ Cell Phone: ________________

Responsible Party Employer: ____Business Phone: _____________________________

Business Address: ____City:__________________State:______________Zip:_____________

INSURANCE COMPANY COVERAGE INFORMATION

Patient Insurance Company: ____ Insurance Phone: _____________________

Policy Number: ______________________ Group Number: ____________________________ Name of Subscriber: _______________________

SECOND INSURANCE COMPANY COVERAGE INFORMATION

Other Insurance Company: ____ Insurance Phone: _____________________

Policy Number: ______________________ Group Number: ____________________________ Name of Subscriber: _______________________

PATIENT ASSIGNMENT AND RELEASE INFORMATION

I, the undersigned, certify that I (or my dependent) have insurance coverage with ____ and assign directly to Dr. Ana D. Lipson all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by the aforementioned insurance company. I hereby authorize Dr. Ana D. Lipson to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsibly Party Signature: _____________________________________ Relationship to Patient: __________________ Date: ______________