

# REGISTRATION

(PLEASE PRINT)

**CARY M. GOLUB, D.P.M., F.A.C.F.A.S., P.C.**

854 East Broadway  
Long Beach, New York 11561  
Telephone: (516) 889-2200

Date \_\_\_\_\_

Home Phone \_\_\_\_\_

## PATIENT INFORMATION

Name \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Last Name First Name Initial  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Sex  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_  Single  Married  Widowed  Separated  Divorced  
Patient Employed by \_\_\_\_\_ Occupation \_\_\_\_\_  
Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_  
In case of emergency who should be notified? \_\_\_\_\_ Phone \_\_\_\_\_

## PRIMARY INSURANCE

Person Responsible for Account \_\_\_\_\_ Last Name First Name Initial  
Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Address (If different from patient's) \_\_\_\_\_ Phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Person Responsible Employed by \_\_\_\_\_ Occupation \_\_\_\_\_  
Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_  
Insurance Company \_\_\_\_\_  
Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_  
Names of other dependents covered under this plan \_\_\_\_\_

## ADDITIONAL INSURANCE

Is patient covered by additional insurance?  Yes  No  
Subscriber Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_  
Address (If different from patient's) \_\_\_\_\_ Phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Subscriber Employed by \_\_\_\_\_ Business Phone \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_  
Names of other dependents covered under this plan \_\_\_\_\_

## ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with \_\_\_\_\_  
Name of Insurance Company(ies)  
and assign directly to Dr. \_\_\_\_\_ 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 insurance. I hereby authorize the doctor to  
release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

\_\_\_\_\_  
Responsible Party Signature

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date