Ella Zavolunova, MD

33-47 91st Street #1J
Jackson Heights, NY 11372
(718)424-2332
Fax:(718)424-2386

63-61 99th Street #G1
Rego Park, NY 11374
(718)896-2332
(718)896-2334

REGISTRATION *(PLEASE PRINT)*

MOBILE PHONE: _____ HOME TELEPHONE _____

WORK PHONE #: _____ E-MAIL ADDRESS _____

IN CASE OF EMERGENCY _____ Relationship: _____

PATIENT'S INFORMATION

◯ **NEW PATIENT** ◯ **Existing Patient**

◯ Single ◯ Married ◯ Minor

PATIENT'S LAST NAME (APELLIDO):_____ FIRST NAME (PRIMER NOMBRE): _____

ADDRESS (DIRECCION):_____APT#: _____CITY: _____ State: ____ZIP CODE:_____

D.O.B: (CUMPLEAÑOS): _____ PATIENT'S SS#:_____

SEX: MALE FEMALE AGE (EDAD): _____

How did you hear about us? _____

INSURANCE (SEGURO):_____**INSURANCE ID # (# DE SEGURO):**_____

CO PAY: $_____ DEDUCTIBLES: ◯ YES ◯ NO

If new patient, please indicate prior physician's information: (Informacion del Doctor anterior)

NAME OF THE DR: _____Address: _____

Phone #: _____ Fax #: _____

PARENT/ GUARDIAN INFORMATION

INSURED'S NAME (Nombre):_____

Relationship to Patient (Relaccion al Paciente):_____

INSURED'S SOCIAL SECURITY #:_____ D.O.B:_____

EMPLOYED BY:_____ City _____OCCUPATION _____

SECONDARY INSURANCE INFORMATION

SECONDARY INSURANCE:_____

INSURED'S NAME:_____ Relationship to Patient: _____

ID #:_____ SS #:_____

PHONE #: _____ CO PAY: $_____ DEDUCTIBLES: ◯YES ◯NO

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information to all claims or benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits for services rendered or for services to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents. At I will be bound by this signature as though the undersigned had personally signed the particular claim. I hereby authorize insurance to pay and hereby assign directly to First Choice Pediatrics, P.C. (Ella Zavolunova, M.D.) all benefits, if any and otherwise payable to me for services as described on the claim forms. I understand, I am financially responsible for all charges incurred, I further acknowledge that any insurance that benefits, when received by me and paid to First Choice Pediatrics, P.C. (Ella Zavolunova, M.D.), will be credited to my account, in accordance with the above-said assignment. I hereby agree and understand that if, I receive payment from my insurance company for services rendered by Ella Zavolunova, M.D., I am to endorse the check and mail with the statement to her office. I clearly understand that it is still my responsibility to make sure that the bill is paid in a reasonable amount of time. If for any reason a portion of my bill is not covered by my insurance company, I further agree to make arrangements for prompt payment of my bill. If I fail to do so, I understand that First Choice Pediatrics P.C. will bill the primary insurance holder. If I fail to pay by the first notice there will be an additional 20% charge of my total bill on the second and third notice. After no response or payment, my bill will be sent to a Collection Department, I am responsible for any fees from the collection department and courts.

X_____

SIGNATURE OF THE PATIENT, PARENT, LEGAL GUARDIAN OR REPRESENTATIVE

_____ _____

RELATIONSHIP TO THE PATIENT **DATE**