Hillcrest Hospital
Atrium Medical Offices
6770 Mayfield Road,
Suite 441
Mayfield Heights, OH 44124

440-449-6798

REGISTRATION

(please print)

Date _____

PATIENT INFORMATION

Name _____ Soc. Sec. # _____
Last Name First Name Initial

Address _____ Home Phone _____

City _____ State _____ Zip _____ Cell Phone _____ E-Mail: _____

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? _____ Primary Care Physician _____ Phone _____

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 Is this a Workers Compensation Claim? ☐ 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 # _____ BWC Claim # _____

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)

I authorize the physician office to submit any and all health care information to my health insurance program(s) for their review and payment. I understand that I am financially responsible for all services whether or not paid by insurance. I assign all insurance benefits for services rendered directly to Dr. Silberman, that would otherwise be payable to me. I further understand that with certain health care plans, I may be responsible for deductibles, co-payments, and varying rules concerning hospitals, labs and care. I authorize the use of this signature on all insurance submissions.