NEW PATIENT REGISTRATION

Dr. Stephen Tosk

Please print clearly to help avoid billing errors

Patient Last Name _____ First _____ MI _____

Mailing Address _____ Apt or Unit # _____

City _____ State _____ Zip _____

(_____) _____ _____ _____

Home Telephone Cell Number Work Telephone e-mail

Date of Birth _____ Age _____ Social Security # _____

Marital Status: Single Married Divorced Other **Sex:** Male Female

Employment Status: Employed Full Time Employed Part Time Full Time Student Unemployed Retired

GUARANTOR NAME-Person to Bill if Other Than Patient

Mailing Address _____ Apt or Unit # _____

City _____ State _____ Zip _____

***Assignment and Release**: I hereby authorize and direct my insurance benefits to be paid directly to Dr.Tosk and I understand I am financially responsible for any and all non-covered services provided by Dr. Tosk.*

Patient's Signature: _____ **Date:** _____

********** *Below for Office Use Only* **********

NEW PATIENT - INITIAL VISIT

Date of Service: _____ **Amt. Paid This Visit:** _____

New Pt. Exam Level: 99201 99202 99203 99204 99205

9894____ Manip.	97110 Thera Ex .	97012 Mech. Traction	97535 ADL	97010 H/C Packs	97014 E-Stm / Unattnd
97026 Infra Diath.	97035 Ultra Sound	97140 Man. Therapy	97039 Hydro Ther.	97124 Massage	

DIAGS: (1) _____ **(2)** _____ **(3)** _____ **(4)** _____

☐ **Block Pt. Statements**