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Patient Name

Last	First	Middle	Nickname	Sex

Date of Birth / Social Security Number

Month	Day	Year	Social Security Number

Mailing Address

Street	City	State	Zip

Physical Address (Check here if same as Mailing Address☐)

Street	City	State	Zip

Telephone Numbers

Home	Work	Mobile

Email Address (Check here for no promotional or informational emails ☐)

Primary Insurance (Check here for self pay☐)

Company	Group Number	Policy Number

Insurance Cardholder Information

Full Name	Birth Month	Day of Birth	Birth Year

Secondary Insurance (if applicable)

Company	Group Number	Policy Number

Insurance Cardholder Information

Full Name	Birth Month	Day of Birth	Birth Year

Signature **Date**

I understand that payment is due at the time of service. I am responsible for payment of any charges incurred, including any balance not paid by my insurance. I will be responsible for collections costs by a third party, legal fees interest and any other costs incurred in the collection of this account. I authorize release of such information as needed to above insurance companies for reimbursement of claims. I authorize the above insurance companies to release payment directly to Robin Berger MD PC. I authorize Dr. Berger to diagnose and treat me.