

Maya Shetreat-Klein, MD; Pediatric Neurology

Patient Registration

Patient Information:

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Home *** Social Security #: _____

_____ Cell Email: _____

_____ Work Marital Status: M S W D Separated

If Patient is under age 18yrs:

Name of Parent / Guardian: _____

Address of Parent / Guardian: _____ City: _____ State: _____ Zip: _____

Pharmacy Information:

Pharmacy Name: _____ Phone: _____

Emergency Contact Information:

Contact Name: _____ Phone: _____ Relationship: _____

How were you referred? _____

I hereby authorize Full Circle Women's Health to release any medical information necessary to process any insurance claims and to apply for benefits on my behalf for covered services furnished to me by Full Circle Women's Health. I certify that the insurance information supplied is correct and up to date and understand I will be responsible for any services not covered by insurance. I also understand that any co-payment or co-insurance is due at time of service.

Patient Signature: _____ Date: _____

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