Douglas J. Spiel, M.D.
(732) 548-2000

Date _____

Name _____ **Birthdate**_____ **SS#** _____

Address_____

City_____ **State**_____ **Zip**_____

Phone (home)_____ **(work)** _____ **(cell)** _____

Age_____ **Sex**: male / female **Single** / **Married** / **Widowed** / **Divorced** / **Separated**

Who is responsible for this account?_____**Relationship to patient** _____

Do you have insurance? YES / NO

Name of Insurance_____

Name of secondary insurance (if applicable) _____

Who should be contacted in case of an emergency?_____
Phone #_____

ASSIGNMENT OF INSURANCE BENEFITS
The undersigned hereby authorized the release of any information relating to all claims for benefits submitted on behalf of myself and or dependents. I further expressly agree and acknowledge that my signature on this document authorized 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 myseld and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I, _____ hereby authorize _____
(Patient Name) (Insurance Company)
To pay and hereby assign directed to DOUGLAS J. SPIEL, M.D. all benefits, if any, otherwise payable to me for his services as described on the attached forms. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when recieved by and paid to DOUGLAS J. SPIEL, M.D. will be credited to my account in accordance with the above assignment.

Patient Signature _____