



Rajiv Bansal M.D.
Avigayil Neuburger, PA-C

PATIENT REGISTRATION

Date: _____

Name _____ SS# _____

Street Address _____ Birth Date _____ Sex M F

City _____ State _____ Zip _____

Home _____ Work _____ Cell _____

Email Address _____

Spouse's Name _____ Spouse's Phone # _____

Emergency Contact _____ Tel# _____ Relationship _____

REFERRING DOCTOR

Referring Doctor _____ Telephone _____

Street Address _____ City _____ State _____ Zip _____

PATIENT EMPLOYER INFORMATION

Employer Name _____ Occupation _____

Employer Address _____

City _____ State _____ Zip _____ Telephone _____ Ext _____

INSURANCE

Primary Insurance Company _____

ID# _____ Group # _____ Tel # _____

Secondary Insurance Company _____

ID# _____ Group # _____ Tel# _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFIT

- ❖ I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.
- ❖ I hereby authorize LIGHTe Associates to apply for benefits on my behalf for covered services rendered by him or his order.
- ❖ I am responsible for obtaining all appropriate referrals in accordance with my insurance plan.
- ❖ I certify that the information I have reported with regard to my insurance coverage is correct. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

DATE _____ SIGNATURE _____

2001 Marcus Ave., Ste E130
Lake Success, NY 11042
Tel: 516-437-6900
Fax: 516-437-6904

524 Old Country Rd.
Plainview, NY 11803
Tel: 516-496-1060
Fax: 516-437-6904