THE SUE MEDICAL GROUP
RONALD SUE, M.D. | ERIC SUE, M.D.

NEW PATIENT REGISTRATION

Date:		SSN: __ __ __ - __ __ - __ __ __ __
First Name:	MI:	Last Name:
Date of Birth: __ __/ __ __ / __ __ __ __		Marital Status:
Gender: ☐ Female ☐ Male ☐ Other		Patient Ethnicity:
Patient Race:		Language:
Hand Dominance: ☐ Right ☐ Left ☐ Ambidextrous		Communication Preference: ☐ Home ☐ Mobile ☐ Work

Home Address

Address 1:	
Address 2:	
City:	State:
Zip:	Country:
County:	

Contact Details

Home:	Mobile:
Work:	Fax:
Email:	

Emergency Contact Details

Contact:	Phone:
Relationship:	Mobile:

Other Details

Occupation:	Pharmacy/Phone #:
Employer:	Referred By:
Employer Address :	Insurance Plans:

Authorization to Release Information

I hereby authorize my physician to release any information acquired in the course of my treatment to process insurance issues, including prior authorizations.

Signature: _____ Date: _____

Financial Responsibility Acknowledgement

I am aware that I am responsible for charges incurred on this account. I have been advised that payment is expected on the date of service unless other arrangements are specifically made with my doctor or staff member. I am aware that payment is also due regardless of insurance allowance or reimbursement.

Signature: _____ Date: _____