Rebecca Jaffe, MD
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Wilmington, DE 19808
(302) 992-0200

Appt. Date _____/_____/_____

INFORMATION: (Please Print Clearly)

Patient Name: Last _____First _____Middle Init. ____ Birthdate: ____/_____/_____

Address: _____ Home #(_____)_____

(city, state, zip, apt.#) _____ Apt #_____

Status: Single/ Married/ Divorced/ Separated/ Widow/Civil Union Social Security #: _____/_____/_____ Gender: **M / F**

Spouse Name: _____Birthdate: ____/_____/_____S.S. #: _____/____/_____Phone _____

Patient Employer: _____City _____ State ____ Work # (_____) _____

Cell Phone: (_____)_____ E MAIL: _____@_____

RACE: (circle) White Black/African American Hispanic /Latino Asian Native American Refused to report

Ethnicity: _____ Hispanic and/or Latino _____ Not Hispanic and/or Latino _____Refused to report

Preferred Language: English Spanish Other_____

RESPONSIBLE PARTY (if patient is minor)

Name: Last_____ First _____ Home #: _____DOB_____

Address: (if different from above)_____City _____State_____ Zip_____

Employer: _____ Work # _____ Relationship to patient: _____

PRIMARY INSURANCE

Company Name: _____ Member ID #: _____Group # _____

Insured Name & DOB: _____ Insured Employer: _____Relationship to Patient: _____

SECONDARY INSURANCE

Company Name: _____ Member ID #: _____Group # _____

Insured Name & DOB: _____ Insured Employer: _____Relationship to Patient: _____

ADDITIONAL INFORMATION:

***In case of an emergency, who may we contact other than above. Name _____**

Phone # _____ Relationship to patient: _____

***List any dependents/family members seen in this office? _____**

AUTHORIZATION: (must be 18 or legal guardian to sign authorization)

I authorize payment directly to Rebecca Jaffe MD & Associates, PA, for all benefits payable to me or my dependents under the terms of my insurance policy with respect to treatment/services rendered to me. I understand that I am financially responsible for any balance not covered by my insurance. I also understand that this office only submits to insurance companies for office visits for Aetna/US Healthcare, Highmark BCBS of Delaware, Cigna, Devon Health, Diamond State Partners, Coventry Healthcare, United Healthcare, Unison and Traditional Medicaid & Medicare. If you have an insurance carrier not listed above, please ask if we are a participating provider.

MEDICAL AUTHORIZATION:

I authorize the release of any medical information necessary to process claims that are submitted by this office on my behalf.

Signature: _____Patient/ Guardian Date: _____