

**DR. RICHARD BRAVER, D.P.M.**  
**DR. SUNEEL K. BASRA, D.P.M.**  
**DR. PHILIP MESSENGER, D.P.M.**  
**DR. STEPHANIE HOCHMAN, D.P.M.**

140 Grand Avenue Englewood, N.J. 07631 201-569-7672  
4-14 Saddle River Road Fair Lawn, N.J. 07410 201-791-1881  
1069 Ringwood Avenue, Haskell, NJ 07420 973-831-1774

**WELCOME TO OUR OFFICE**

PATIENT INFORMATION:

SEX: MALE [ ] FEMALE [ ]

BIRTH DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

SOCIAL SECURITY# \_\_\_\_ - \_\_\_\_ - \_\_\_\_

LAST NAME: \_\_\_\_\_

FIRST NAME: \_\_\_\_\_ M.I. \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: ( ) \_\_\_\_\_

WORK PHONE: ( ) \_\_\_\_\_

CELL PHONE ( ) \_\_\_\_\_

INSURED'S INFORMATION

EMPLOYER OF INSURED: \_\_\_\_\_

YOUR RELATIONSHIP TO INSURED:

SELF [ ] SPOUSE [ ] CHILD [ ] OTHER [ ]

INSURED PERSON : [ ] MALE FEMALE [ ]

INSURED'S NAME (if other than self): \_\_\_\_\_

LAST NAME: \_\_\_\_\_

FIRST NAME: \_\_\_\_\_ M.I. \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: ( ) \_\_\_\_\_

WORK PHONE: ( ) \_\_\_\_\_

DATE OF BIRTH : \_\_\_\_\_

SOCIAL SECURITY # : \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**INSURANCE INFORMATION**

PRIMARY INSURANCE NAME: \_\_\_\_\_

IDENTIFICATION # \_\_\_\_\_ Group # \_\_\_\_\_

SECONDARY INSURANCE NAME: \_\_\_\_\_

IDENTIFICATION # \_\_\_\_\_ Group # \_\_\_\_\_

**HOW WILL YOU BE PAYING TODAY?**

CHECK [ ] CASH [ ] VISA/MC/AMEX [ ] WORKMEN'S COMP [ ] MVA [ ] COPAY AMOUNT \_\_\_\_\_

Credit Card # \_\_\_\_\_ Exp date: \_\_\_\_\_

IF OTHER THAT THE ABOVE PLEASE DISCUSS PAYMENT WITH THE OFFICE RECEPTIONIST

**AUTHORIZATION / RESPONSIBILITY AGREEMENT:**

I HEREBY AUTHORIZE MY INSURANCE COMPANY TO PAY THE PROCEEDS OF ANY BENEFITS TO DR. RICHARD T. BRAVER, AND/OR ASSOCIATES AND WILL BE RESPONSIBLE FOR THE REMAINING BALANCE. A COPY OF THIS FORM CAN BE CONSIDERED AS AN ORIGINAL FOR INSURANCE PURPOSES.

I HEREBY AGREE TO PAY MY ACCOUNT AS SERVICES ARE PROVIDED. HOWEVER, IF I AM NOW OR IN THE FUTURE BECOME A MEMBER OF A HMO OR MANAGED CARE PLAN I WILL PROVIDE PROPER AUTHORIZATION OR REFERRALS FOR THIS AND UPCOMING VISITS. SHOULD MEDICAL CARE BE GIVEN AND PROPER AUTHORIZATION OR REFERRAL NOT OBTAINED, I AGREE TO PAY ANY OUTSTANDING BALANCE DIRECTLY TO ACTIVE FOOT AND ANKLE CARE CENTER .

UNDER CERTAIN CIRCUMSTANCES, I MAY HAVE ARRANGED FOR THE DOCTOR TO BILL MY INSURANCE COMPANY ON MY BEHALF; I CLEARLY UNDERSTAND THAT THE BILL IS STILL MY RESPONSIBILITY AND I WILL MAKE SURE THE BILL IS PAID IN A REASONABLE TIME FRAME (45 DAYS). IF FOR ANY REASON ANY PORTION OF MY BILL IS NOT PAID BY MY INSURANCE, I AGREE TO PAY PROMPTLY. ANY OUTSTANDING BILLS MAY BE SENT TO A BILLING AGENCY AND A 15% SERVICE FEE WILL BE ADDED.

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_

Save as: welcome 2010