

# PATIENT INFORMATION

Please Print

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Date of Birth \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Address \_\_\_\_\_ Apt or Lot # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Referred By \_\_\_\_\_ Your SS# \_\_\_\_\_

Male \_\_\_\_\_ Female \_\_\_\_\_ Marital Status: Single Married Other

Name of Spouse \_\_\_\_\_ Spouse Date of Birth \_\_\_\_\_

Spouse's Employer \_\_\_\_\_ Employer Phone \_\_\_\_\_

Other Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_

Do you attend school? \_\_\_\_\_ Full Time \_\_\_\_\_ Part Time \_\_\_\_\_

Name of School \_\_\_\_\_

Alternate Home Address \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

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**PRIMARY INSURANCE** \_\_\_\_\_ Effective Date \_\_\_\_\_ PPO/HMO \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

ID# \_\_\_\_\_ Group # \_\_\_\_\_

Insured's Name \_\_\_\_\_ Relationship to you \_\_\_\_\_

**SECONDARY INSURANCE** \_\_\_\_\_ Effective Date \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

ID# \_\_\_\_\_ Group # \_\_\_\_\_

Insured's Name \_\_\_\_\_ Relationship to you \_\_\_\_\_

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I certify that the information given by me in applying for payment under title XVII of the Social Security Act is correct. I authorize release of any information necessary for medical care or in processing of medical claims. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to Frank Mastandrea, M.D., P.A. and authorize such physician to submit a claim to my insurance company for payment. I understand that I am financially responsible for any balance not covered by my insurance. A photocopy of these assignments shall be valid as the original.

Patient's Name Printed \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_