Dr. Aria

PATIENT INFORMATION

Name_____ Sex F M
LAST FIRST MI

Address_____
STREET CITY

_____HOME PHONE _____WORK PHONE_____
STATE ZIP CODE

BIRTH DATE _____/_____/_____ S.S._____-_____-_____ **S**INGLE **M**ARRIED **D**IVORCED **O**THER_____

EMPLOYED Y or N STUDENT WHOM MAY WE THANK FOR REFERRING YOU? _____

NAME OF PRIMARY CARE PHYSICIAN_____

SECURE PHONE NUMBER TO LEAVE TEST RESULTS/PERSONAL MESSAGES_____

EMPLOYER_____OCCUPATION_____

ADDRESS_____

EMERGENCY CONTACT_____PHONE_____

INSURANCE INFORMATION (We use an outside billing service and therefore appreciate your cooperation in writing your insurance information below as well as providing us with a copy of your insurance card)

Insurance company_____Address_____

Is this an: (circle) HMO PPO INDEMNITY OTHER_____

Name of insured_____ SEX F or M Relationship to Patient_____

ID_____Group_____SS_____-_____-_____DOB_____

Employer_____Work phone_____

How much is your deductible?_____How much have you used?_____

Do you need a referral for today's visit_____Name of responsible party_____

I hereby give permission for Dr. Aria (or his Designee) provide medical care for me (or my minor child). Assignment of Medicare/Medicaid Benefits: I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr.Aria for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release the health care financing adm., and its agents any information needed to commercial insurance benefits: I hereby authorize Dr. Aria to collect payment for services redendered by Dr. Aria. I understand and agree that I am financially responsible for charges not paid under this insurance policy should the account be turned over to a collection agency for collection. The undersigned shall pay all collection agency, court costs and reasonable attorneys' fees.

SIGNATURE_____**DATE**_____

Secondary Insurance *(We will submit to your secondary as a courtesy, if it doesn't pay, you will be liable)*

*Insurance company*_____*Name of insured*_____*M F*
*ID*_____*Group*_____*S.S.*_____/_____/_____*Relationship to patient*_____