

# Welcome to our Practice!

Will you please help us by providing us with the following confidential information?

## PATIENT INFORMATION:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Mailing address: \_\_\_\_\_ Email Address: \_\_\_\_\_

Home phone #: \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

May we contact you by Text? \_\_\_\_\_ May we contact you by email? \_\_\_\_\_

SS#: \_\_\_\_\_, Driver's License: \_\_\_\_\_, Sex: M F Date of Birth \_\_\_\_\_

Employer: \_\_\_\_\_, Address, City, State, Zip: \_\_\_\_\_

Emergency contact name: \_\_\_\_\_, Phone # \_\_\_\_\_

Spouse's name: \_\_\_\_\_, Spouse's Cell #: \_\_\_\_\_, Spouse's work # \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_, Employer Address, City, State \_\_\_\_\_

How were you referred to our office? \_\_\_\_\_

**In the event that we must contact you for scheduling changes, etc, please indicate the best PHONE NUMBER during business hours to phone you:** \_\_\_\_\_

## INSURANCE INFORMATION:

Primary Insurance Company: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_, State: \_\_\_\_\_ Zip \_\_\_\_\_, Phone: \_\_\_\_\_

Policy holder name: \_\_\_\_\_, SS# \_\_\_\_\_, Birth date: \_\_\_\_\_

Group # or policy # \_\_\_\_\_, Member ID # \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_, State: \_\_\_\_\_, Phone: \_\_\_\_\_

Policy holder name: \_\_\_\_\_, SS# \_\_\_\_\_, Birth date: \_\_\_\_\_

Group# or policy #: \_\_\_\_\_, Member ID# \_\_\_\_\_

I hereby authorize the release of any information to my insurance company or companies, including records of examinations, diagnosis and/or treatment. This release is solely for the purpose of facilitating the billing and reimbursement, directly to Dr. Mario Maritato of insurance benefits under which I am entitled. I hereby agree that I am financially responsible for all treatment rendered, and understand that estimated payment will be made at time of treatment.

Date: \_\_\_\_\_, Patients Signature: \_\_\_\_\_