



Please indicate which doctor you will be seeing:

Ralph J. Venuto, M. D. \_\_\_ Michael P. Weinstein, M. D. \_\_\_ Scott K. Forman, M. D. \_\_\_  
Nicholas E. Rose, M. D. \_\_\_ Stephen A. Mikulak, M. D. \_\_\_

Account #: \_\_\_\_\_

Today's Date: \_\_\_\_\_

**PATIENT INFORMATION**

<b>Name:</b>	<b>Date of Birth:</b>	<b>Age:</b>
<b>Address One:</b>	<b>Social Security #:</b>	
<b>City:</b>	<b>Male:</b>	<b>Female:</b>
<b>State:</b>	<b>Zip:</b>	
<b>Home Phone#:</b>	<b>Ethnicity: Hispanic/Latino Not Hispanic/Latino</b> <b>Decline to Report</b>	
<b>Work Phone#:</b>	<b>Race: Asian Native Hawaiian Other Pacific Islander</b> <b>American Indian Alaska Native</b> <b>Black/African American White</b> <b>More than 1 race Decline to report</b>	
<b>Cell Phone#:</b>	<b>Marital Status:</b>	
<b>Email:</b>	<b>Emergency Contact:</b>	
<b>Employer:</b>	<b>Emergency Phone#:</b>	
	<b>Emergency Relationship:</b>	

**SPOUSE/GUARANTOR INFORMATION**

<b>Name:</b>	<b>Date of Birth:</b>
<b>Address One:</b>	<b>Social Security#:</b>
<b>Address Two:</b>	
<b>City:</b>	<b>Employer:</b>
<b>State</b>	<b>Employer Address:</b>
<b>Zip:</b>	<b>Employer City:</b>
<b>Home Phone</b>	<b>Employer State:</b>
<b>Work Phone#:</b>	<b>Zip:</b>
<b>Cell Phone#:</b>	

**INSURANCE INFORMATION**

<b>Primary Insurance:</b>	<b>Secondary Insurance:</b>
<b>Certificate#:</b>	<b>Certificate#:</b>
<b>Group Number:</b>	<b>Group Number:</b>
<b>Subscriber Date of Birth:</b>	<b>Subscriber Date of Birth</b>
<b>Subscriber Name:</b>	<b>Subscriber Name:</b>

1. I hereby assign the insurance benefit payment, both basic and major medical to which I am entitled, directly to the doctor rendering service. I understand that I am financially responsible for the charges not covered by the assignment. A photocopy of this authorization is accepted with the same authority as the original.
2. I hereby authorize the physician to release any information acquired in the course of my treatment to another physician of my choice, my insurance company, my attorney or to me at my above address, within 1 year of the date of this signature.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature (Guardian/Parent if patient is a minor)

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Relationship to Patient