**Barry R. Katz, M.D. Harry H. Shephard, M.D. Sanjay K. Reddy, M.D. Raaj K. Popli, M.D. Jorge A. Zapatier, M.D.**

**Robert A. Shultz, D.O. Sarah F. Osorio, APRN Hanna R. Agard, APRN Jeanine L. Febres, APRN**

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient Name:** |  | **Referring Doctor:** |  |
| **Address: (Street)** |  |
| **(City, State, Zip)** |  | **Email:** |  |
| **DOB:** | **Home #:** | **Cell Phone #** |
| **Sex:** | **Race:** | **Marital Status:**  | **Occupation:** |
| **Employer:** | **Work #: Ext.** |
| **Employer's Address:** | **Living Will: Yes or No** |
|  |  |  |  |  |  |  |  |  |  |
| **Spouse/Partner Name:** | **Spouse/Partner DOB:** |
| **Spouse/Partner Employer:** | **Spouse/Partner Phone #:** |
|  |  |  |  |  |  |  |  |  |  |
| **# 1 Emergency Contact:** | **Phone #:** | **Relation:** |
| **# 2 Emergency Contact:** | **Phone #:** | **Relation:** |
| **# 3 Emergency Contact:** | **Phone #:** | **Relation:** |
|  |  |  |  |  |  |  |  |  |  |
| **Primary Insurance** | **Phone #:** |
| **ID #** | **Group #** |
| **Secondary Insurance:** | **Phone #:** |
| **ID #** | **Group #** |
|  |  |  |  |  |  |  |  |  |  |
| **# 1 Pharmacy:** | **Address:** | **Phone #:** |
| **# 2 Pharmacy:** | **Address:** | **Phone #:** |

AUTHORIZATION FOR RELEASE OF INFORMATION: THE UNDERSIGNED HEREBY AUTHORIZES SAID PROVIDER TO RELEASE ALL

INFORMATION PERTAINING TO THE ABOVE SAID PATIENT’S TREATMENT TO HIS/HER INSURANCE COMPANY OR COMPANIES.

AUTHORIZATION FOR PAYMENT: I HEREBY AUTHORIZE THAT PAYMENT BE MADE DIRECTLY TO THE PROVIDER OF SERVICES. I

 UNDERSTAND AND AGREE THAT, REGARDLESS OF MY INSURANCE STATUS, I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE ON MY

ACCOUNT FOR ANY PROFESSIONAL SERVICESRENDERED. I HAVE READ ALL THE INFORMATION ON BOTH SIDES OF THIS SHEET AND HAVE

COMPLETED THE ABOVE ANSWERS. I CERTIFY THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL

NOTIFY YOU OF ANY CHANGES TO THE ABOVE INFORMATION.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_