Nancy Aria, MD

PATIENT INFORMATION

Name____ Sex F M
LAST FIRST MI

Address____
STREET CITY

_________________________________HOME PHONE __________________ Cell PHONE________________________
STATE ZIP CODE

BIRTH DATE ______/_______/______ S.S.________-_________-________ SINGLE MARRIED DIVORCED OTHER______________

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____

Email ADDRESS____ # for text messages:______________________________

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______________________