Nancy Aria, MD

PATIENT INFORMATION

Address	Name					Sex F M				
STREET CITY	LAST		FIRS	Т	MI					
HOME PHONE Cell PHONE STATE ZIP CODE BIRTH DATE	Address									
STATE ZIP CODE BIRTH DATE/	STREET	CITY								
BIRTH DATE	STATE ZIP CODE	Н	IOME PHONE	(Cell PHONE					
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 messagges: 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< td=""> 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 Ihereby give permission for Dr. Aria (or his Designes) provide medical care for me (or my minor child). Assignment of Medicare benefits be made either to me or on my behalf to Dr. Aria 1 understand and agree that 1 am financially responsible for Aria. I understand and agree that 1 am financially responsible for services reference or on my behalf to Dr. Aria 1 understand and agree that 1 am financially responsible for theores on private medicare benefits be made either to me or on my behalf to Dr. Aria 1 understand and agree that 1 am financially responsible for theores on private medicare benefits be made either to me or on my behalf to Dr. Aria 1 understand and agree that 1 am financially responsible for theores on private medicare benefits be made either to me or on my behalf to Dr. Aria 1 understand and agree that 1 am financially respon</dob<>										
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Is this an: (circle) HMO PPO INDEMNITY OTHER										
Name of insured SEX F or M Relationship to Patient IDGroup SS	Insurance company		Address							
IDGroupSSDOB	Is this an: (circle) HMO PPO INDEM	NITY OTH	ER							
Employer	Name of insured		SEX F or M	Relationship to	Patient					
How much is your deductible?How much have you used?Do you need a referral for today's visitName 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 req 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 a any holder of medical information about me to release the health care financing adm., and its agents any information needed to commercial insurance benef 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 pa this insurance policy should the account be turned over to a collection agency for collection. The undersigned shall pay all collection agency, court costs ar reasonable attorneys' fees.	ID	Group	SS		DOB					
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	SIGNATURE					DATE				

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

Insurance company		M F				
ID	Group	<i>S.S.</i>	/	/	Relationship to patient	