CESARE P PERAGLIE, MD FACS FASCRS

PATIENT INFORMATION

PATIENT NAME: _____ BIRTHDATE: _____ AGE: _____

PATIENT SS#: _____ SEX: _____ MARITAL STATUS: _____ DRIVER'S LICENSE: _____

ADDRESS: _____ APT #: _____ CITY: _____ STATE: _____ ZIP: _____

HOME#: (____) _____ CELL#: (____) _____ BEEPER#: (____) _____

EMPLOYER'S NAME: _____ OCCUPATION: _____

EMPLOYER'S ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

EMPLOYER'S #: (____) _____ EXT _____ REFERRED BY: _____

PRIMARY CARE PHYSICIAN: _____ PHONE#: (____) _____

PRIMARY INSURANCE INFORMATION

PLEASE CIRLE ONE

INSURANCE COMPANY'S NAME: _____ HMO PPO POS OTHER

CLAIMS ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

POLICY #: _____ GROUP #: _____ GROUP NAME: _____

INSURED'S NAME: _____ INSURED'S DATE OF BIRTH: _____

INSURED'S SOCIAL SECURITY #: _____ INSURED'S EMPLOYER: _____

EMPLOYER'S ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

EMPLOYER'S PHONE #: (____) _____ OCCUPATION: _____

SECONDARY INSURANCE INFORMATION

PLEASE CIRLE ONE

INSURANCE COMPANY'S NAME: _____ HMO PPO POS OTHER

CLAIMS ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

POLICY #: _____ GROUP #: _____ GROUP NAME: _____

INSURED'S NAME: _____ INSURED'S DATE OF BIRTH: _____

INSURED'S SOCIAL SECURITY #: _____ INSURED'S EMPLOYER: _____

NEXT OF KIN INFORMATION

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME #: (____) _____ WORK #: (____) _____ CELL #: (____) _____

RELEASE AND ASSIGNMENT OF BENEFITS

I AUTHORIZE CESARE P PERAGLIE, MD, PA TO RELEASE ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIMS. I HEREBY ASSIGN ALL MEDICAL AND/OR SURGICAL BENEFITS TO WHICH I AM ENTITLED. PRIVATE INSURANCE AND ANY OTHER NON-GOVERNMENT SPONSORED PROGRAMS TO CESARE P PERAGLIE, MD, PA. A PHOTOCOPY OF THIS ASSIGNEMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE COMPANY.

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CLAIMS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE AND IN THE EVENT IT BECOMES NECESSARY TO INSTITUTE LEGAL PROCEEDING TO COLLECT THE SUMS DUE, THEN THE PATIENT OR RESPONSIBLE PARTY SHALL BE RESPONSIBLE FOR ANY AND ALL COURT COSTS AND REASONABLE ATTORNEY FEES PLUS COLLECTION AGENCY FEES. I AUTHORIZE CESARE P PERAGLIE, MD, PA TO OBTAIN A CREDIT REPORT AND INVESTIGATE MY CREDIT SHOULD PAYMENT ARRANGEMENTS BE NECESSARY.

SIGNATURE _____ DATE _____