John R. Pedrotty, Jr., M.D. PATIENT INFORMATION SHEET ACCT#____

PATIENT NAME		D.O	.B/_	/	
ADDESS:				<u>_</u>	
Number and Street	City		ate	Zip	
EMAIL ADDRESS:	@				
HOME PHONE:WORK PHONE: _		CELL PH	ONE		
DRIVERS LICENSE #GENDER:	F M	AGE:	SSN:	_//	
MARITAL STATUS: MARRIED DIVORCED	_ WIDOWED _	SEPARATED _	SINGLE	≣	
BIRTHPLACE:					
PATIENTS EMPLOYER/SCHOOL	OCCUPATION				
BUSINESS ADDRESS:					
Number and Street	(City	State	Zip	
SPOUSE/P.	ARENT INFOR	MATION			
NAME:					
LAST	FIRST			MIDDLE	
ADDRESS:Number and Street	City		State	Zip	
EMPLOYER:	•		State	Ζιρ	
BUSINESS ADDRESS:					
SSN: DATE OF					
HOME PHONE:WORK PHONE:		CELL PHON	E:		
EMERGENCY CONTACT					
NAME:		MII	DDLE		
ADDRESS:					
Number and Street	City	State	Zip		
HOME PHONE: WORK PHONE:		RELATIONSHIP: _			
INSURANCE INFORMATION					
RIMARY:SECONDARY:					
POLICY/GROUP #	POLICY/GROUP #				
I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION (UNDER TITLE XX111 (OR ITS INTERMEDIARIES).INSURANCE COMPANIES OR OTHER THIRD PARTY PAYORS FOR PROCESSING OF PAYMENT. I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO DR. PEDROTTY. TO BEST OF MY KNOWLEDGE ALL INFORMATION GIVEN FOR MEDICAL SERVICES RENDERED IS TRUE. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY UNPAID BALANCE DUE TO DR. PEDROTTY AND SHOULD THE ACCOUNT BE REFERRED TO AN ATTORYNY FOR COLLECTION, I SHALL PAY ALL REASONABLE ATTORNEY FEES AND COLLECTION EXPENSES. I ALSO UNDERSTAND THAT IF MY INSURANCE COMPANY DOES NOT PROCESS AND HONOR MY CLAIM WITHIN 45 DAYS, I WILL BE OBLIGATED TO START MAKING SUBSTANTIAL PAYMENTS ON MY ACCOUNT.					

DATE: _____ PATIENT/PARENTS SIGNATURE ____

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