John R. Pedrotty, Jr., M.D.

PATIENT INFORMATION SHEET **ACCT#** _____

PATIENT NAME _____D.O.B. _____/_____/_____

ADDESS: _____
Number and Street City State Zip

EMAIL ADDRESS: _____@ _____

HOME PHONE: _____WORK PHONE: _____CELL PHONE _____

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/PARENT INFORMATION

NAME: _____
LAST FIRST MIDDLE

ADDRESS: _____
Number and Street City State Zip

EMPLOYER: _____

BUSINESS ADDRESS: _____

SSN: _____- _____ - _____ DATE OF BIRTH: _____ /_____/_____

HOME PHONE: _____WORK PHONE: _____ CELL PHONE: _____

EMERGENCY CONTACT

NAME: _____
LAST FIRST MIDDLE

ADDRESS: _____
Number and Street City State Zip

HOME PHONE: _____ WORK PHONE: _____ RELATIONSHIP: _____

INSURANCE INFORMATION

PRIMARY: _____ **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 _____