WELCOME TO OUR OFFICE!

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WE APPRECIATE YOUR COOPERATION IN FILLING OUT THIS FORM

PATIENT INFORMATION

PATIENT'S NAME (Last, First)	MARITAL STATUS S M W D	DATE OF BIRTH	AGE	SEX	SOC. SEC. NUMBER

STREET ADDRESS: ☐ Permanent ☐ Temporary	CITY AND STATE:	ZIP CODE:	HOME PHONE NUMBER

PATIENT'S EMPLOYER:	OCCUPATION: (Indicate If Student)	BUSINESS PHONE NUMBER

EMPLOYER'S STREET ADDRESS:	CITY AND STATE:	ZIP CODE:

PERSON TO NOTIFY IN CASE OF EMERGENCY:

RELATION TO PATIENT: ☐ SPOUSE ☐ MOTHER ☐ FATHER ☐ OTHER _____

PHONE NUMBER:

IF THE PATIENT IS A MINOR OR STUDENT / PERSON RESPONSIBLE FOR PAYMENT

NAME: (Last, First)	RELATION:	DATE OF BIRTH	AGE	SEX	SOC. SEC. NUMBER:

STREET ADDRESS: ☐ Permanent ☐ Temporary	CITY AND STATE:	ZIP CODE:	HOME PHONE NUMBER

EMPLOYER:	OCCUPATION: (Indicate If Student)	SOC. SEC. NUMBER	BUSINESS PHONE NUMBER

EMPLOYER'S STREET ADDRESS:	CITY AND STATE:	ZIP CODE:

MEDICAL INSURANCE INFORMATION

NAME OF POLICY HOLDER:	POLICY NUMBER:	GROUP NUMBER:

NAME OF INSURANCE COMPANY:

INSURANCE COMPANY STREET ADDRESS:	CITY AND STATE:	ZIP CODE:

DENTAL OR SECONDARY MEDICAL INSURANCE INFORMATION

NAME OF POLICY HOLDER:	POLICY NUMBER:	GROUP NUMBER:

NAME OF INSURANCE COMPANY:

INSURANCE COMPANY STREET ADDRESS:	CITY AND STATE:	ZIP CODE:

I HEREBY AUTHORIZE THE FOLLOWING:

1. DIRECT PAYMENT FROM MY INSURANCE CARRIER(S) , FOR ACCEPTED INSURANCE ONLY TO: **DR. DAVID V. VALAURI**
2. THE RELEASE OF ANY MEDICAL INFORMATION.
3. PHOTOCOPIES OF THIS FORM TO BE AS VALID AS THE ORIGINAL.

I ALSO UNDERSTAND THAT I AM PERSONALLY RESPONSIBLE FOR BILLINGS FOR TODAY'S VISIT AND ANY FUTURE MEDICAL OR SURGICAL BILLS, COPAYMENTS, DEDUCTABLES, AND ANY AND ALL BILLS RENDERED WHICH ARE NOT COVERED OR ALLOWED, OR NOT PAID WITHIN 60 DAYS BY THIRD PARTY PAYERS, TOGETHER WITH ALL COLLECTION COSTS.

_____ _____

PATIENT'S OR GUARDIAN'S SIGNATURE: DATE:

REFERRED BY:	STREET ADDRESS, CITY STATE ZIP	PHONE NUMBER: