PATIENT INFORMATION **Patient Information** First Name MI Last Name Street Address City State Home Phone (Zip Wk () Cell () D.O.B SSN# Maiden Name Sex: M/F Marital Status Single Married Other Student (Yes/No) Full time Part time Employer Employer Address Driver's License Number Primary Care Physician Primary Care Physician Phone# () Emergency Phone () Emergency Contact Relationship: **Insurance Information** Insured's Social Security # Primary Insurance Co. Insurance# Group# Insured Name: Insured Address Insured Date of Birth: Home Phone: () Wk Phone: () Sex: M / F Insured Employer Relationship of Patient to Insured Secondary Insurance Co. Insurance# Group# Insured Insured Social Security # Insured Address Insured Date of Birth: Home Phone: () Wk Phone: () Sex: M / F Insured Employer Relationship of Patient to Insured Do you have a Third Insurance (Tertiary)? Yes/No If Yes see receptionist for an additional form. **Responsible Party (fill out only if other than the patient)** Last Name: MI First Name: Street Address City State: Zip Relationship to Patient: Date of Birth: SS# Sex: M / F Employer: Work Phone: () Home Phone: (Other Family Members that are Patients of Dennis Dilley M.D. and/or Christopher Calabria M.D. Name Relationship Relationship Name **Signing This Form Indicates That All Charges Have Been Explained Payment Policy:** All professional services rendered are charged to the patient. The patient is responsible for payment regardless of insurance coverage. Full payment is

All professional services rendered are charged to the patient. The patient is responsible for payment regardless of insurance coverage. Full payment is expected at time of each office visit unless arrangements have been made in advance. Billing information will be provided to expedite patient reimbursement form private insurance carriers.

Authorization of Payment:

I hereby authorize the provider of services to release medical information concerning my examination and/or treatment for insurance purposes and to receive direct payment for medical benefits payable to me for services rendered.

Patient if over 18 or Responsible Party	Signature:	Date	:
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