

NEW PATIENT INFORMATION

Please circle: Mr. Mrs. Miss Ms. Dr. Fr.

First Name _____ Last _____ Middle _____

Address _____

City _____ State _____ Zip Code _____

Phone #'s: Home _____ Cell _____ Work _____

Patient's Social Security# _____ Patient's Date of Birth _____

Referred by (circle one): Dr/PCP Friend Family Yellow pages Ins. Directory Internet other _____

Primary Care Physician _____ Phone _____

Patient a MINOR Yes No Responsible Party's Name _____ DOB _____

Marital status of patient (circle one): Single Married Widowed Divorced Partner Legally Separated

Employment Status (circle one): Employed Retired Student Not employed Occupation _____

Employed by: _____ Phone _____

**In case of Emergency, please notify _____ Phone # _____

Insurance Company _____ ID # _____ Co-Pay \$ _____

Subscriber's Name _____ Subscriber's SSN# _____ Date of Birth _____

Subscriber's Employer _____ Phone _____

Secondary Insurance Company _____

I hereby authorize payment of medical benefits to Dr. Joseph Leonetti for services rendered to me. I authorize the release of medical or any other information necessary to process my claims. I acknowledge and understand that I am fully responsible for any deductible, coinsurance and/or non-covered benefit amounts. It's my responsibility to obtain all authorizations and to know if Dr. Leonetti is a current provider. I understand that payment for services is expected at time of service, unless prior arrangements have been made with the billing department. I agree that Dr. Leonetti will bill my insurance company as a courtesy to me, and if my insurance company does not pay within 90 days, the balance of my account will be my responsibility. If my account is turned over to a collection agency, I agree to pay all the collection costs, statutory fees, and attorney's fees. I am also aware that there will be a missed appointment fee of \$25.00 responsible to me, if I fail to give 24 hr notice of cancellation. **Please Note: We do not call to remind you of your appointment.

******It is my responsibility to update my information Medical or Insurance, when it changes. 4-08***

Signature _____ Date _____