NEW PATIENT INFORMATION

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

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First Name Last Middle

____
Address

City ____________________________ State____________________ Zip Code_____________

Phone #'s: Home________________ Cell _________________ Work_______________________

Email Address: ____

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 #______________________

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Insurance Company _______________________ID # _________________ Co-Pay $_____________

Subscriber's Name________________ Subscriber's SSN#_______________ Date of Birth____________

Subscriber's Employer ________________________________Phone _________________________

Secondary Insurance Company____

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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. There will be a $45.00 fee assessed to all returned checks. Also, after the first statement, a $5.00 fee will be assessed to each statement thereafter. **Please Note: We do not call to remind you of your appointment, unless authorized by you on your paperwork. **It is my responsibility to update my information both Medical or Insurance, when it changes.***

Signature____ Date________________________