Patient Information Sheet

JAMES A. TOTORO, M.D.

Date: _____ - ____ - _____ **Please Print**

Patient Name: _____ **Sex:** M F

Date of Birth: _____ - ____ - _____ **Age:** _____ **SSN:** _____

Marital Status (Circle One) M S D W **Race:** _____

Patient Address: _____

City: _____ **ST:** _____ **Zip:** _____

Home Ph: (____) _____ **Work Ph:** _____ **Cell/Pgr:** _____

Referring Physician: _____ **Phone:** (____) _____

Employer: _____

Work Address: _____

City: _____ **ST:** _____ **Zip:** _____

Spouse Name: _____ **SSN:** _____

Date of Birth: _____ - ____ - _____ **Work Ph:** (____) _____

Spouse Employer: _____

Work Address: _____ **City/ST/Zip:** _____

Emergency Contact (Outside home) _____ **Phone:** (____) _____

Do you have insurance? (Check One) **Yes** ____ **No** ____ ***** Please present insurance card to receptionist. *****

Name of Primary Insurance _____ **Secondary:** _____

Policy Holder Name _____ **Policy Holder Name** _____

Answer the following if patient is under the age of 21

Mother's Name: _____ **SSN:** _____

Mother's DOB _____ - ____ - _____ **Work Phone:** _____

Employer: _____ **Address:** _____

Father's Name: _____ **SSN:** _____

Father's DOB _____ - ____ - _____ **Work Phone:** _____

Employer: _____ **Address:** _____

Authorization for services / Please read the following and sign at the bottom of this form.

I hereby authorize payments directly to the Physician, staff, or facility for medical services rendered. I understand I am responsible for any portion of my bill not covered by my insurance company, whether as a co-pay, co-insurance, deductible, or a non-covered service. I understand office co-pays are due at the time services are rendered. I also understand all the above and state that the information provided herein is true and correct to the best of my knowledge.

Signature: _____ ***Date:*** _____

Acknowledgement of Receipt of Notice of Privacy Practices.

This acknowledges I have received the Notice of Privacy Practices from my provider at er

Signature: _____ ***Date:*** _____