PATIENT REGISTRATION FORM FOR DR VASILE

NAME_____
LAST FIRST MIDDLE INITIAL

ADDRESS_____
STREET CITY, STATE ZIP CODE

TELEPHONE_____
HOME CELL NUMBER

EMAIL _____

*****CIRCLE PREFERRED METHOD OF CONTACT – OKAY TO LEAVE A MESSAGE? YES / NO**

SEX___RACE_____DOB_____SS#_____

ETHNICITY_____PREFERRED LANGUAGE_____

EMPLOYER NAME, ADDRESS AND PHONE:

_____

Emergency Contact (Name and Phone No):_____

Referring Dr_____ Family Dr_____

Allergies:_____

MEDICAL INSURANCE:

_____

Primary Ins Name | Policy Holder Name and DOB | ID | Group #

_____

Secondary Ins Name | Policy Holder Name and DOB | ID | Group #

Assignment of benefits: I assign med/surg benefits to which I am entitled including Medicare, Medicaid and private ins to Anthony A. Vasile DO. This assignment will remain in effect until revoked by me in writing. Photocopy is to be considered as valid as an original. I understand I am financially responsible for charges whether or not paid by said ins and authorize assignee to release all information necessary to secure payment. I request that payment of medigap benefits be made to Anthony A Vasile DO for any services he provided me. I authorize any holder of medical info about me to release to my supp insurer any info needed to determine benefits payable for related services

FEE POLICY: Our office now charges a fee for missed appointments or visits not cancelled at least 24 hours prior. A **$10.00** processing fee will be charged to replace lost scripts.

PATIENT SIGNATURE **DATE**

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