

WILLIAM A. PORTUESE, M.D.

PATIENT INFORMATION (PLEASE PRINT)

NAME _____ DATE _____
FIRST MIDDLE LAST

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE () _____ () _____ () _____
HOME CELLULAR WORK

BIRTHDATE / / GENDER: M F MARITAL STATUS: SINGLE MARRIED
 DIVORCED WIDOWED

OCCUPATION _____ EMPLOYER _____

EMAIL _____ @ _____

YOUR PRIMARY CARE PROVIDER _____

WHO CAN WE THANK FOR REFERRING YOU TO THIS OFFICE? _____

INSURANCE INFORMATION

INSURANCE _____ 2ND INSURANCE _____

SUBSCRIBER NAME _____ SUBSCRIBER NAME _____

BIRTH DATE _____ BIRTH DATE _____

ID# _____ ID# _____

GROUP# _____ GROUP# _____

PT RELATION TO SUBSCRIBER _____ PT RELATION TO SUBSCRIBER _____

PLEASE COMPLETE THIS SECTION ONLY IF SOMEONE OTHER THAN THE PATIENT IS FINANCIALLY RESPONSIBLE

RELATIONSHIP TO PATIENT _____

GUARANTOR/PERSON RESPONSIBLE FOR PAYMENT _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE () _____ CELLULAR () _____

EMPLOYER _____ OCCUPATION _____

EMPLOYER'S ADDRESS _____ CITY _____ STATE _____ ZIP _____

IN CASE OF EMERGENCY CONTACT INFORMATION

FRIEND OR RELATIVE WHO IS NOT LIVING AT SAME ADDRESS AS PATIENT TO BE NOTIFIED

CONTACT NAME _____ RELATIONSHIP TO PATIENT _____

HOME () _____ CELLULAR () _____

I AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE PHYSICIAN. I AUTHORIZE THE DOCTOR OR INSURANCE COMPANY TO RELEASE ANY INFORMATION REQUIRED FOR MEDICAL CLAIMS. I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE DUE

PATIENT SIGNATURE _____

GUARANTOR'S SIGNATURE _____