

Patient Information Form

Date _____
Pat. ID _____

Please print

Name _____ Social Security # _____
(First) (M.) (last)

Address _____ DOB _____ AGE _____

City/State/Zip _____ Sex M F Marital Status S M D W

Home # _____ Work # _____ Cell # _____

EMAIL _____

Occupation _____ Employer _____ Address _____

Spouse's name _____ Emergency Contact _____ Phone # _____

Insurance Information (circle one) HMO PPO Major Medical Auto Work Comp Medicare Medicaid

Name of policyholder _____ Policy # _____

Insurance Co Name _____ Group # _____

Secondary Insurance (circle one) HMO PPO Major Medical Auto Work Comp Medicare Medicaid

Name of policyholder _____ Policy # _____

Insurance Co Name _____ Group # _____

Is your condition due to an: A) Auto Accident B) Work Injury C) Other Accident

D) Unknown Cause E) Illness F) Sport Injury

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and me. I authorized payment from my insurance carrier directly to Dr. Steven J. Melilli with the understanding that all monies will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, all fees for professional services rendered to me will be immediately due and payable. In the event of default, I promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to affect collection.

Patient Signature _____ Date _____