Carmen Roman, M.D. PATIENT INFORMATION (Please print clearly in BLACK ink)

Patient Name: _____ Date: _____/_____/_____

Sex: [ ] Male [ ] Female Social Security Nbr: _____ - ____ - _____ Driver License Nbr: _____

Address: _____ City: _____ State: ____ Zip: _____

Birth Date: _____/_____/_____ Age: _____ Status: [ ] Single [ ] Married [ ] Widowed [ ] Divorced

Phone No: ( ) _____ - _____Occupation: _____

Responsible Person: _____Occupation: _____

Employed by: _____ Phone No: ( ) _____ - _____

City: _____ State: ___ Zip: _____ OK to call work phone? [ ] No [ ] Yes

Spouse: _____ Occupation: _____

Employed by: _____ Phone No: ( ) _____ - _____

Address: _____ City: _____ State: ____ Zip: _____

Referring Physician: _____

Medical Insurance: [ ] No [ ] Yes

Insurance Company: _____ Health Plan/Issuer/Payer ID: _____

Address: _____ City: _____ State: ____ Zip: _____

Member ID: _____ Group Name: _____ Group Nbr: _____

Emergency Contact: _____ Phone No: ( ) _____ - _____

Address: _____ City: _____ State: ____ Zip: _____

ASSIGNMENT OF BENEFITS: I hereby assign ALL medical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance or any other health plan to Carmen Roman, M.D. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

MISSED APOINTMENTS: Missed appointments are not covered by insurance. I agree to pay a fee of $100.00 if I miss an appointment or fail to give 24-hours prior notice to cancel or reschedule.

Signature: _____ Date: _____/_____/_____