

PATIENT ENTRANCE DATA

Date _____ Home Phone _____
Patient _____
First Name _____ Last Name _____ Initial _____
Street Address _____
City _____ State _____ Zip _____
Sex M F Age _____ Birthday _____ Single Married Widowed Divorced
Social Security # _____ E-Mail Address _____
Work Phone _____ Cellular Phone _____
Insured's Name _____
First Name _____ Last Name _____ Initial _____
Relationship to Insured: Self Spouse Child Other

Employer

Company name _____ Occupation _____
Address _____ Phone _____
City _____ State _____ Zip _____

Spouse

Name _____
First Name _____ Last Name _____ Initial _____
Birthday _____ Social Security # _____
Employer name _____ Phone _____
Address _____
City _____ State _____ Zip _____

Patient Insurance Information

Please any and all insurance coverage you or your spouse has applicable in this case.
 Medicare Auto Accident Other
 Medicaid Health Insurance/Major Med
 Blue Cross Worker's Compensation
I. D. /Policy # _____
Group # _____
Date of Accident _____
Insurance Company Name _____ Adjuster _____
Address/Phone _____ Claim # _____

Medical Information

How did you hear about us? _____
Present Complaint _____
Known Medical Problems _____
Pregnant Yes No Pacemaker Yes No
Family Physician _____
Person to Contact in emergency (Name and Phone#) _____

Patient Agreement

ASSIGNMENT AND RELEASE
I, the undersigned, have insurance coverage with _____
Name of Insurance Company
And assign directly to Dr. Corinella and/or Dr. Davis all medical benefits, if any, otherwise payable to them for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Insured/Guardian _____ Date _____