Name of the Patient	Sex: M F	Date of Birth: ____/____/_____ Age:_____	Marital Status Single [ ] Married [ ] Divorced [ ] Widow [ ]
Address:		**Ethnicity:** Hispanic [ ] Non-Hispanic [ ]	**Social Security Number:**
City State Zip Code		Home Phone :	**Do You Have a Living Will ?**
Email Address:		Cell Phone:	Yes [ ] No [ ]

Race: White [ ] Black /African American [ ] American Indian/ Alaskan Native [ ] Asian [ ] Other Island Pacific _____

Other Race: _____

Name of person **Financially** Responsible : **(Main Insured)**	Circle One: **Self Spouse Parent(s)**	Date of Birth **Of Main Insured** ____/____/_____	**Social Security of Main Insured**

Name of Employer for **Main Insured**	Occupation of **Main Insured**:
Address of Employment for **Main Insured**	Phone Number
Name of Spouse/Significant Other **OR** Parent or Guardian **OF THE PATIENT**	CONTACT PHONE NUMBER
PATIENTS: Place of Employment or Higher Education / Occupation	Telephone Number
Address: State:	Zip Code:
Reason for your Visit:	Referred by:

Person to Contact in Case of Emergency	**Relationship to Patient**	**Telephone Number**
Address:		

Medicare? Yes [ ] No [ ]	**Medicare #**	Medicaid ? Yes [ ] No [ ]	Medicaid #	Medicaid Effective date(s)

Name of **Primary Insurance** *(Please provide us with a copy)* if you are employed :your employer insurance is **mandatory** primary Insurance

Name of **Secondary Or Supplemental Insurance Company** (Please provide us with a copy)

Lifetime Signature

I certify that the information contained on this form is correct to the best of my knowledge. I also understand that if at any given date or time **my insurance information changes or updates, It will be my sole responsibility as the patient to inform and update my PCP's office**. In addition, I authorize the release of any and all medical information necessary to process claim(s) for all treatment and payments. I also authorize the payment(s) of medical benefits to **Andres Patron D.O,P.A** TIN: 05-0560236 provider and or supplier of services. I hereby agree, regardless of insurance coverage, that I am responsible for all charges incurred. Payment is EXPECTED at the time of service. We will bill your insurance as a courtesy. However, the patient is accountable, to know and understand their insurance policy and coverage. Furthermore, I understand that I am financially responsible for any services not covered by my insurance carrier and I agree to pay any and all charges, collection costs, attorney fees, and any other charges associated to the collection of any unpaid amount(s) and or balance(s) outstanding. This consent is to include but not limited to any outstanding tests, pending results or procedures and laboratory charges incurred. I, the undersigned, hereby authorize the provider and whomever else he may designate as his assistant (s), to administer those treatments and procedures which in his/her opinion are deemed necessary.

_____ _____

Patient Signature **Date**