JOHN A. AZZATO, MD, PC

Patient's Name: ____
LAST **FIRST** **MI**

Address: ______________________ Date of Birth ______________ Male____ Female____

City, State, Zip; ______________________ Single____ Married ____ Separated ____ Divorced ____ Widowed____

Home Phone: ______________________ Social Security No: ______________________

Work Phone: ______________________ Referring Physician: ______________________

Cell Phone: ______________________ Family Physician: ______________________

Preferred Pharmacy: ______________________ **Email:** ______________________

Employer: ______________________ Were you injured on the job? Yes ____ No ____

Emp Address: ______________________ Were you injured in an auto accident? Yes ____ No ____

City, State where accident occurred: ______________________ INJURY **DATE**: ____________

Do you have Attorney? Yes ____ No ____ Attorney Name: ______________________

INSURANCE / WORKERS' COMPENSATION

Primary: ______________________ **Secondary:** ______________________

Patient's relationship to policyholder: Self ____ Spouse ____ Child ____ Other ______________

Policyholder: ______________________ SSN: ______________ Birthdate: ____________

PATIENT SURVEY

How did you hear about us? Patient ___ Physician ___ Phone Book ___ Website ___ Advertisement Media ___

FINANCIAL STATEMENT & AUTHORIZATION FOR TREATMENT

I understand that I am financially responsible to my physician, John A. Azzato, MD for services rendered and charges not covered by insurance. I understand my insurance will be filed as a courtesy to me and allow payment of any filing to be made to John A. Azzato, MD PC. I understand Dr. Azzato does not accept third party liability insurance.

____
Signature of Patient or Legal Guardian Date