*PATIENT INFORMATION

Last Name _____ First_____
Primary Address _____
City _____ State _____ Zip_____
Home Phone _____
Cell Phone _____
Work Phone _____
Northern Address (if applicable) _____
City _____ State _____ Zip_____
Email: _____

Birthday
_____

Marital Status
___ Married
___ Single
____ Widow
____ Divorced

Gender
____ Male
____ Female

Emergency Contact Name _____ Phone _____

***PRIMARY INSURANCE**
Name _____
Phone _____
ID# _____ Group# _____
Person insured __ Self __Spouse Parent__
Parent__
Insured's name if not patient _____
_____
Person insured date of birth if not patient _____
_____

SECONDARY INSURANCE
Name _____
Phone _____
ID# _____ Group# _____
Person insured __ Self __Spouse

Insured's name if not patient

Person insured date of birth if not patient

REFERRALS
How did you first hear about Dr. Menendez?
_____

PRIMARY CARE PHYSICIAN
Physician's Name _____
Physician's Phone _____

***NOTICE OF PRIVACY ACT**
I have read a copy of Julian R. Menendez Notice of Privacy Practice. _____ (Initials)*

ASSIGNMENT AND RELEASE
I, the undersigned certify that I (or my dependant) have insurance coverage and assign directly to Dr Julian Menendez all Insurance benefits, if any, otherwise payable to me 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 payment of benefits. I authorize the use of this signature on all insurance submission. _____ **(Initials)***

MEDICARE AND INSURANCE AUTHORIZATION
I request that payment of authorized Medicare or insurance benefits be made on my behalf to Dr. Julian Menendez for any services furnished by that physician. I authorize any holder of medical information about me to be released to the Health Care Financing Administrator and its agent's needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other insurance" is indicated in the item 9 of the HICFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductibles, coinsurance, non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier. _____ **(Initials)***

Signature _____ **Date** _____