

# STEVEN A. BATTAGLIA, M.D. INC CHARLES R. BATTAGLIA, M.D.

(Please Print)

<b>Today's date:</b>		<b>Referring Doctor:</b>					
PATIENT INFORMATION							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Partner	
Street address:			Social Security no.:		Birth date: / /		Age: Sex: <input type="checkbox"/> M <input type="checkbox"/> F
City:			State:		ZIP Code:		
Home phone no.:		Cell phone no.:					
Occupation:		Employer:			Employer phone no.: ( )		

INSURANCE INFORMATION							
Type of Insurance: (Please give your insurance card to the receptionist.)							Co-payment: \$
Person responsible for bill:		Birth date: / /	Address (if different):			Home phone no.: ( )	
Occupation:	Employer:	Employer address:				Employer phone no.: ( )	
Subscriber's name:		Subscriber's S.S. no.:	Birth date: / /	Policy no.:		Group no.:	
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
Name of secondary insurance (if applicable):		Subscriber's name:			Group no.:		

IN CASE OF EMERGENCY				
Contact:		Relationship to patient:	Home phone no.: ( )	Cell phone no.: ( )
<p>The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Steven A Battaglia M.D. or insurance company to release any information required to process my claims.</p>				
<hr/> <i>Patient/Guardian signature</i>			<hr/> <i>Date</i>	