RAFAEL ANTUN, M.D., P.A.
VICTOR A. POLITANO, M.D., P.A.
PATIENT REGISTRATION AND INFORMATION FORM

PLEASE PRINT CLEARLY DATE: _____

GENERAL INFORMATION

PATIENT'S NAME: _____ AGE: _____
Last Name First Name M.I. Maiden Name

DATE OF BIRTH: _____/_____/_____ SEX: _____ S.S.# _____/_____/_____ MARITAL STATUS: _____

ADDRESS: _____
Street Apt. # City State Zip Code

MAILING ADDRESS: _____
Street Apt. # City State Zip Code

HOME PHONE: _____ WORK PHONE: _____ LOCAL PHONE: _____

RELIGION: _____

EMERGENCY CONTACT: _____

RELATIONSHIP: _____ HOME PHONE: _____ WORK PHONE: _____

ADDRESS: _____

EMPLOYER INFORMATION

PATIENT'S EMPLOYER: _____ PHONE: _____

ADDRESS: _____
Street City State Zip Code

POSITION/OCCUPATION: _____

SPOUSE: _____ S.S. #: _____/_____/_____

SPOUSE'S EMPLOYER: _____

ADDRESS: _____
Street City State Zip Code

POSITION/OCCUPATION: _____

REFERRAL INFORMATION

NAME OF FAMILY PHYSICIAN: _____ PHONE: _____
WHO REFERRED YOU TO THIS PRACTICE?: _____
FAMILY PHYSICIAN ☐ HEALTH PLAN ☐ OTHER ☐ (Specify) _____

INSURANCE INFORMATION

NAME OF PRIMARY INSURANCE:	NAME OF SECONDARY INSURANCE:
GROUP NUMBER: _____	GROUP NUMBER: _____
ID NUMBER: _____	ID NUMBER: _____
SUBSCRIBER: _____	SUBSCRIBER: _____
RELATION TO PATIENT: _____	RELATION TO PATIENT: _____

PHYSICIAN'S RELEASE AND ASSIGNMENT

I hereby authorize any holder of medical or other information about me to release to Social Security Administration and Centers for Medicare and Medicaid Services or its intermediate carriers any information needed for this or a related Medicare claim. I further authorize the release of any medical information required by my insurance carrier, health care plan or third party administrator. I understand that I am financially responsible for all medical charges for services rendered by Rafael Antun, M.D., P.A. or Victor A. Politano M.D., P.A. I am also responsible for providing to Rafael Antun, M.D., P.A. or Victor A. Politano, M.D., P.A. an authorization number from my insurance company, health care plan or third party administration. In the event that my insurance does not cover the fees for any services or procedures provided by Rafael Antun M.D., P.A. or Victor A. Politano, M.D., P.A., I understand that I am financially obligated to pay those fees. I hereby direct insurer to pay, without equivocation, directly to Rafael Antun, M.D., P.A. or Victor A. Politano M.D., P.A., all benefits due him as a result of this claim. A copy of this release and assignment will be as valid as the original.

PATIENT NAME:_____ PATIENT SIGNATURE:_____