Wayne A. Colizza, M.D.

Patient Name _____ Title _____ DOB _____ Age _____

Address _____ City _____ State _____ Zip _____

Work Telephone _____ Home Telephone _____ Driver's License # _____

SS# _____ Employer's Name & Address _____

EMERGENCY CONTACTS

Name _____ Relationship _____ Address _____

Work Telephone _____ Home Telephone _____

REFERRING SOURCE

How did you hear of this office? (please check one)

Friend ____ Relative ____ Doctor ____ IMCC ____ Hospital ____ Yellow Pages ____

Brochure ____ Newspaper Ad ____ Newsletter ____ Other _____

Please list the name of the person and/or facility that referred you to this office.

Mr. ____ Mrs. ____ Miss ____ Ms. ____ Dr. ____ _____

GUARDIAN INFORMATION

If the patient is a minor child, please complete information below.

Father's Name & Address _____

Father's Home Telephone _____ Work _____

Father's SS# _____ Age _____ Date of Birth _____

Mother's Name & Address _____

Mother's Home Telephone _____ Work _____

Mother's SS# _____ Age _____ Date of Birth _____

If legal guardian is other than parent, please complete below.

Guardian's name & address _____ Age _____

Home Telephone _____ Work _____ SS# _____ Relationship to the child _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY

Name of Insurance _____

Address _____

Policyholder _____

Date of birth _____

SS# _____

Employer _____

Policy # _____ Group # _____

SECONDARY INSURANCE COMPANY

Name of Insurance _____

Address _____

Policyholder _____

Date of birth _____

SS# _____

Employer _____

Policy # _____ Group # _____

FINANCIAL POLICY

All charges are due and payable at time of service.
In the event of an automobile or work related injury, this office must be provided with verifiable insurance and/or authorization for treatment or the patient will be responsible for all charges incurred.

***** I WILL BE PAYING BY ***** Cash ____ Check ____

AUTHORIZATION/SIGNATURE ON FILE/ASSIGNMENT

I understand that I am financially responsible for the total charges incurred for medical services with this office and that payment is expected at time of service. In the event that I receive treatment that is not paid at time of service such as hospital and/or emergency care I authorize this office to act as my agent and bill my insurance carrier directly for these services and to receive payment directly from my carrier.
I fully understand that regardless of the status of insurance coverage, I am fully responsible for any amounts not covered by insurance and that this office does not accept as payment in full, amounts allowed by individual insurance carriers other than those mandated by contract or law.

Signature or Mark _____ Date _____

Witness (in the event a mark is used) _____