Ramiro Nieves, M.D.

PATIENT INFORMATION

PATIENTS NAME: _____
LAST NAME FIRST NAME MIDDLE INITIAL

DATE OF BIRTH: _____ AGE : _____ SOCIAL SECURITY NUMBER: _____

SEX: ❒ F ❒ M MARITAL STATUS: ❒ SINGLE ❒ MARRIED ❒ WIDOWED ❒ DIVORCED

HOME ADDRESS: _____
STREET ADDRESS CITY STATE ZIP CODE

TELEPHONES: _____ _____ _____
HOME CELLULAR WORK

PLACE OF EMPLOYMENT: _____ OCCUPATION: _____

ADDRESS: _____ TELEPHONE: _____

SPOUSES NAME: _____ GUARDIAN'S NAME (IF MINOR): _____

PLACE OF EMPLOYMENT: _____ OCCUPATION: _____

ADDRESS: _____ TELEPHONE: _____

LANGUAGES SPOKEN BY PATIENT: _____

PRIMARY INSURANCE: _____ POLICY #: _____ GROUP #: _____

ADDRESS: _____ TELEPHONE: _____

NAME OF INSURED: _____ DATE OF BIRTH: _____

SECONDARY INSURANCE: _____ POLICY #: _____ GROUP #: _____

ADDRESS: _____ TELEPHONE: _____

NAME OF INSURED: _____ DATE OF BIRTH: _____

EMERGENCY CONTACT: _____
NAME RELATIONSHIP TELEPHONE

MEDICAL ALLERGIES: _____

PRIMARY CARE PHYSICIAN: _____ TELEPHONE: _____

I, HERBY AUTHORIZE MY DOCTOR, AND/OR HIS ASSOCIATES, TO APPLY FOR BENEFITS TO MY INSURANCE COMPANY ON MY BEHALF FOR SERVICES PROVIDED TO ME. I REQUEST THAT PAYMENT FROM MY INSURANCE COMPANY BE MADE DIRECTLY TO MY PHYSICIAN. I AUTHORIZE THE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS THIS CLAIM.
I UNDERSTAND THAT I AM RESPONSIBLE TO PAY ANY CHARGE NOT REIMBURSED BY MY INSURANCE COMPANY. I AGREE TO BE RESPONSIBLE FOR ANY RESONABLE FEES INCURRED IF I SHOULD BECOME DELINQUENT IN PAYMENT OF MY ACCOUNT AND IT MUST BE TURNED OVER TO AN ATTORNEY OR COLLECTION AGENCY.
WITH MY APPROVAL AND KNOWLEDGE, THE ABOVE NAMED PHYSICIAN AND/OR HIS ASSOCIATES ARE AUTHORIZED TO PERFORM ANY MEDICAL TEST NECESSARY TO DETERMINE PROPER DIAGNOSIS AND TREATMENT.

_____ _____
SIGNATURE OF PATIENT OR GUARDIAN IF PATIENT IS UNDER 18 YEARS OF AGE DATE

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