

**PATIENT INFORMATION FORM**

Please print and provide complete information for each item.

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_ Maiden Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Social Security No.: \_\_\_\_\_

If you have been seen here before, under what name? \_\_\_\_\_

If you live in a skilled nursing facility, we need the name, address, and phone number. Do you live in a skilled nursing facility? Yes / No

If yes, Facility Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Facility Address: \_\_\_\_\_

**EMPLOYER INFORMATION:**

Employer's Name: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Telephone: \_\_\_\_\_

Occupation: \_\_\_\_\_

**PARENT/SPOUSE:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

Social Security No.: \_\_\_\_\_

Other Contact (other than spouse): \_\_\_\_\_ Relationship: \_\_\_\_\_

Contact's Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

Referred by: \_\_\_\_\_ Family Physician: \_\_\_\_\_

**MEDICARE INFORMATION:**

Medicare Number: \_\_\_\_\_ Medicaid Number: \_\_\_\_\_

**INSURANCE INFORMATION:**

Insurance Company: \_\_\_\_\_ Name of Policyholder: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

Group Number: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Policyholders' Employer and Address: \_\_\_\_\_

(OVER)

**Please read and sign below.**

I hereby authorize **Dr. Robert E. Torti and/or Dr. Bernard F. Godley** and their staff to perform procedures necessary to assess and diagnose my condition properly during any and all visits.

I authorize the release of any information concerning my care for purpose of claims to such agencies, third party payers, doctors and hospitals.

I hereby agree to pay the established charges for services incurred as a patient of either Dr. Torti or Dr. Godley or both. I authorize payment directly to the doctors, herein specified and otherwise payable to me, but not to exceed the regular charges for the period of admission.

I understand that I am financially responsible for ALL charges arising from services rendered to me by Dr. Torti and/or Dr. Godley regardless of insurance coverage.

I will cooperate in seeking, collecting and paying to Dr. Torti and Dr. Godley any and all insurance proceeds. If the insurance proceeds cannot be paid directly to Dr. Torti or Dr. Godley, I agree to collect payment and pay Dr. Torti and/or Dr. Godley within five (5) business days of receipt.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

OR

Signature of Other  
Responsible Person: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_