

**Patient Information Form**

Patient Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
(Last) (First) (Middle)

Cell Phone: \_\_\_\_\_

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

City/ State / Zip: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_  Male  Female Marital Status: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Responsible Party: \_\_\_\_\_ Email Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Business Address: \_\_\_\_\_

Occupation / Type of Work: \_\_\_\_\_

**Insurance Information**

**Primary Insurance:** \_\_\_\_\_  Private  PPO  POS  HMO

Name of Insured: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Insured Social Security #: \_\_\_\_\_ Insured Date of Birth: \_\_\_\_\_

Group Policy #: \_\_\_\_\_ ID #: \_\_\_\_\_ Customer Service #: \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_  Private  PPO  POS  HMO

Name of Insured: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Insured Social Security #: \_\_\_\_\_ Insured Date of Birth: \_\_\_\_\_

Group Policy #: \_\_\_\_\_ ID #: \_\_\_\_\_ Customer Service #: \_\_\_\_\_

Person to notify in case of **Emergency:** \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Please let us know how you were referred to our office:** \_\_\_\_\_

Assignment of Benefits

I hereby authorize and direct my insurance carrier to pay directly to **Flory Isabel Aguilar, M.D.**, benefits due me out the terms of my policy issued by your company. Payment is authorized upon receipt of an itemized statement or claim form for services rendered to me. My policy was in full force and effective at the time these services were rendered. I also acknowledge that I am fully responsible for all co-payments, deductibles and any charges not covered by my insurance at the time of service. I agree to notify you immediately of any changes in my health status or the above information.

Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Minor (if applicable): \_\_\_\_\_