Insurance Information & Authorization

Patient's Name			
	First	Middle	Last
Address , .			Birthdate
Primary Phone: □Home □	Work □Cell	Alternate Phone: □Home □Work □Cell	
Gender:	Race:	Ethnicity:	
SSN:	Preferred	Language: Email:	
ER Contact:	Phone:		Relationship:
Primary Insurance Com	pany		ID#:
Subscriber Name		Birthdate	Group #:
Secondary Insurance Co Subscriber Name	ompany _		ID#:
		Birthdate	Group #:
Tanghetti's appointme	ent policy. I	e is correct/corrected. I acknowledge also acknowledge I have received a ad it contains information about the u	copy of Emil A. Tanghetti's Notice o
Signature X			Date
Insurance Patients Only I request that payment of authorized benefits be made on my behalf to the provider for any services furnished me. understand that <i>all copayments, deductibles and co-insurances are collected at the time of service.</i> I authorize any holder of medical information about me to release to the above listed insurance companies and their agents any information needed to determine these benefits payable for related services.			
Signature X			Date
furnished me. I authoriz Administration and its a	of authorized ze any holde gents any inf care has an	Medicare benefits be made on my belar of medical information about me to reformation needed to determine these be annual deductible of \$155.00 per callansurance.	lease to the Health Care Financing enefits payable for related services. I
Signature X			Date