Edward F. Guarino, M.D., P.C.
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REGISTRATION *Please Print*

Date _____ /_____ /_____ Home Phone _____

Patient Name _____
(Last Name) (First Name) (Initial)

Responsible Party *(if a minor)* _____

Address _____ City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthdate _____ /_____ /_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

SS#_____ Reason for appointment _____

Employer's Name _____ Occupation _____

Business Address_____ Phone_____

Referred by_____ Family Physician _____

INSURANCE

Name of Primary Insurance _____

Address _____

ID#_____ GR# _____ Subscriber's Name _____

Name of Secondary Insurance *(if any)* _____

Address _____

ID#_____ GR# _____ Subscriber's Name _____

Is this a work related injury/condition? ☐ No ☐ Yes If yes, date of onset _____ /_____ /_____

IN CASE OF EMERGENCY NOTIFY_____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with (Name of Insurance Company) _____ and assign directly to Dr. Guarino all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Insured/Guardian_____ Date _____ /_____ /_____

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made to me or on my behalf to Dr. Guarino for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature_____ Date _____ /_____ /_____