

Affiliated Physician Practice, Inc.

Stephen DeSantis, MD - General Surgery

Jonathan Mayer, MD - OB/GYN

Chart Number

Patient Information (Please Print)

Last Name		First Name		Middle Name	
Street Address			City		State
Zip Code	Home Telephone Number		Work Telephone / Cell phone		Patient's Age
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow			Social Security Number		Date of Birth / /
Occupation			Employer		
Emergency Contact Name/ Relationship to Patient				Emergency Contact Telephone	
Referring Dr.	Phone #	Primary Care Dr.	Phone #		
How did you hear about our office?					

Insurance / Insured Information

Name of Insured / Responsible Party/Guarantor		Telephone Number		Work Phone / Cell Phone	
Street Address		City & State		Zip Code	
Marital Status of Insured <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow		Social Security Number		Sex M F	Age / /
Patient's Relationship to the Insured <input type="checkbox"/> Insured <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		Occupation			
Employer		Employer's Address			

Name of Insurance	ID Number	Group Number	Plan Number
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Reason For Visit

Assignment of Benefits - I hereby assign all medical and surgical benefits to which I am entitled, including government programs, private insurance, major medical benefits and any other health plan, to Affiliated Physician Practice. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

Signature of Patient	Date
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