MICHAEL A. TOMEO, M.D.

PATIENT INFORMATION – PLEASE PRINT CLEARLY

LAST NAME ________________________ FIRST NAME ________________ MI _____

ADDRESS ________________________ CITY ________________ STATE ____ ZIP ______

PHONES: HOME # ______________ CELL # ______________ WORK # ______________

BIRTHDATE ____________ SOCIAL SECURITY # ____________________ SEX ________

MARITAL STATUS: Single ____ Married ____ Separated ____ Divorced ____ Widowed ______

EMPLOYER ______________________________ ARE YOU A STUDENT? __________

PRIMARY DOCTOR NAME: ________________________ PHONE: ______________

ADDRESS: ____

CURRENT MEDICATIONS ____

ALLERGIES ____

PURPOSE OF VISIT ______________________ WHO REFERRED YOU? ______________

ASSIGNMENT AND RELEASE - ALL PATIENTS PLEASE READ AND SIGN:

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled including Medicare, private insurance and other health plans to Michael A. Tomeo, M.D. 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. As described in the Billing and Payment Policy, I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY MY INSURANCE.

SIGNATURE ______________________________ **DATE** ________________

PRIMARY INSURANCE:

PLAN ______________________
PATIENT'S RELATIONSHIP TO THE INSURED:
Self _____ Spouse ______ Child ______ Other ____

***If not "SELF"**, please provide subscriber information:*
NAME OF INSURED ______________________
ADDRESS ______________________
____
HOME PHONE ______________________
WORK PHONE ______________________
BIRTHDATE ______________ SEX ________

SECONDARY INSURANCE (IF ANY):

PLAN ______________________
PATIENT'S RELATIONSHIP TO THE INSURED:
Self ______ Spouse _____ Child _____ Other _____

***If not "SELF"**, please provide subscriber information:*
NAME OF INSURED ______________________
ADDRESS ______________________
____
HOME PHONE ______________________
WORK PHONE ______________________
BIRTHDATE ______________ SEX _____

PLEASE PRESENT INSURANCE CARD(S) TO RECEPTIONIST

***************FOR STAFF USE ONLY*****************

PRIMARY
GROUP # ______________________

IDENTIFICATION # ______________________

COPAY $__________ REF______ NO REF _______

SECONDARY
GROUP # ______________________

IDENTIFICATION # ______________________

COPAY $ __________ REF______ NO REF______