

**NEW PATIENT INFORMATION
FRANK CASTILLON, III, MD, PA**

LAST NAME FIRST NAME MIDDLE NAME

ADDRESS/CITY/STATE/ZIP

DATE OF BIRTH AGE **F** **M** **S** **M** **D** **W**
GENDER MARITAL STATUS

DRIVER'S LICENSE/STATE SOCIAL SECURITY #

HOME PHONE WORK PHONE MOBILE PHONE

PATIENT'S EMPLOYER NAME **AND ADDRESS**

JOB DESCRIPTION/TITLE

SPOUSE'S NAME DRIVERS LICENSE #

SPOUSE'S DATE OF BIRTH SPOUSE'S WORK PHONE

SPOUSE'S EMPLOYER

REFERRING DOCTOR

ADDRESS/PHONE #/FAX #

EMERGENCY CONTACT OTHER THAN SPOUSE RELATIONSHIP

EMERGENCY CONTACT ADDRESS AND PHONE NUMBERS

PLEASE HAVE YOUR INSURANCE CARD WITH YOU FOR THIS APPOINTMENT

**PRIMARY INSURANCE COVERAGE

GROUP NUMBER ID NUMBER

PHONE NUMBER OF INSURANCE COMPANY CO-PAY

INITIAL & DATE _____

INSURED NAME _____ PPO HMO INDEMNITY NONE
TYPE OF COVERAGE _____

REFERRAL NUMBER _____ PCP NAME _____

PCP ADDRESS/CITY/STATE/ZIP _____ PHONE _____ FAX _____

**SECONDARY INSURANCE COVERAGE _____

GROUP NUMBER _____ ID NUMBER _____

PHONE NUMBER OF INSURANCE COMPANY _____ CO-PAY _____

INSURED NAME _____ EMPLOYER _____

**SIGNATURE _____ DATE _____

**IF YOU DO NOT HAVE SECONDARY INSURANCE COVERAGE PLEASE SIGN ABOVE

IS THIS WORK RELATED _____ Y _____ N _____ DATE OF INJURY _____

CLAIM NUMBER _____ ADJUSTER _____

INSURANCE COMPANY/ADDRESS _____

All professional services rendered are charged to the patient and necessary insurance forms will be completed on their behalf to expedite insurance carrier payments. The patient is responsible for all co-pays and deductibles. Payment is due at the time services are rendered. In the event surgery is performed, any fees due from the patient will be expected when billed.

Insurance authorizations and assignment: (Please read and sign) I hereby authorize Frank Castillon, III, MD, PA to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician all payments for medical and/or surgical benefits, to include major medical benefits to which I am entitled for medical services rendered to myself or my dependents. I understand that I am responsible for all charges whether or not paid by said insurance. A photocopy of this assignment is to be considered as an original.

I authorize my records to be transmitted electronically and absolve Frank Castillon, III, MD, PA of any kind and all liability if they are received by another party in error.

Signature of patient or parent if minor _____ Date _____

INITIAL & DATE _____