

# PATIENT INFORMATION

Name \_\_\_\_\_ Sex M F (circle one)  
 SSN \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_ Phone \_\_\_\_\_  
 Marital Status \_\_\_\_\_ Primary Care Physician \_\_\_\_\_  
 Referring Physician \_\_\_\_\_  
 Employer \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Work Phone \_\_\_\_\_  
 Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

## GUARANTOR INFORMATION

Name \_\_\_\_\_ SSN \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_ Phone \_\_\_\_\_  
 Relation to Patient \_\_\_\_\_ Employer \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Phone \_\_\_\_\_

## GUARANTOR'S SPOUSE INFORMATION

Name \_\_\_\_\_ SSN \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_ Phone \_\_\_\_\_  
 Relation to Patient \_\_\_\_\_ Employer \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Phone \_\_\_\_\_

## INSURANCE INFORMATION

Do you have Medical Insurance? No Yes (circle one)  
 Name of Primary Insurance \_\_\_\_\_ Subscriber \_\_\_\_\_  
 Phone # \_\_\_\_\_ ID # \_\_\_\_\_ Group # \_\_\_\_\_  
 Name of Secondary Insurance \_\_\_\_\_ Subscriber \_\_\_\_\_  
 Phone # \_\_\_\_\_ ID # \_\_\_\_\_ Group # \_\_\_\_\_

I, the undersigned, understand that the professional services are rendered and charged to me, the patient, and that I am financially responsible for all charges whether or not paid by my insurance company.  
 I accept personal responsibility for payment of charges for services rendered to me by Dr Marc Iseri.  
 If legal proceedings are required to collect this account, I agree to pay all collection costs, including reasonable attorney fees and court costs

\_\_\_\_\_  
 Signed Date

## MEDICARE NOTICE

Dr Marc Iseri, M.D. is not participating in the Medicare Assignment Program and may legally charge you fees in addition to the Medicare determined annual deductible and per visit co-payment. If you have questions concerning your fee, please check with our office staff

\_\_\_\_\_  
 Signed Date