

WELCOME

Fredric A. Santiago, MD, MBA
Patient Information

Please complete all areas Date: _____

Name: _____ Date of Birth _____

Social Security # _____ Single _____ Married _____ Divorced _____ Wid _____

Address _____ City _____

State _____ Zip Code _____ Employer _____

Home Ph _____ Work Ph _____ Cell Ph _____

Spouse _____ Employer _____ Work Ph _____

E-Mail Address: _____

Insurance Information

Primary Insurance Company: _____

Secondary Insurance Company: _____

Please list three contact numbers of persons not living with you, in case of an emergency:

Name _____ Ph # _____ Relationship _____

Name _____ Ph # _____ Relationship _____

Name _____ Ph # _____ Relationship _____

Payment Policy Notification

Payment is due at the time of service. Cash and check payments only please. A \$ 30.00 fee for returned checks. \$25.00 fee for each missed appointment without 24hr notification. Outstanding balances may be subject to accrued interest. Non-payment for past due balances may be grounds for dismissal from the practice and referred to a collections agency.

Authorization For Release of Information, and Payment Of Benefits

I authorize the release of any medical information deemed necessary per my physician, and/or medical information needed to process any claims. I accept full responsibility for payment of services not covered by my insurance company.

Medical Authorization For Treatment

I consent to treatment for myself, or patient named above, including, but not limited to medications, laboratory test, x-rays, or other testing that may be performed or requested by Dr. Santiago, or his representative.

Signed (patient or authorized person) **Date**

Signed (patient or authorized person) **Date**