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.

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

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**