Last Name: _____ First Name: _____

DOB: _____ SSN: _____

Address_____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell: _____Work: _____

E-mail:_____ Employer: _____

Preferred Pharmacy: _____ Phone: _____ City: _____

Primary Insurance: _____ ID#:_____

Subscriber Name: _____ DOB: _____

SSN: _____ Relation to Patient:_____

Secondary Insurance: _____ ID #: _____

Subscriber Name: _____ DOB: _____

SSN: _____ Relation to Patient: _____

Emergency Contact: _____ Relationship: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Proof of Insurance and payment is due at the time of service. I authorize Robert J. Russo MD, PhD/LJCVRI to bill my insurance for services rendered and authorize the release of any information required by my insurance company to process my claims (further detailed in the practices **Assignment of Benefits** document). Any amount not covered by my insurance company will be my responsibility (further detailed in the practices **Financial Policy**)._____ (initials)

The above Information is true to the best of my knowledge.

Patient Signature: _____ Date: _____