Patient's
Last name :_______________ First Name : _______________ MI:______

Address : ____

City : _______________ State : __________ Zip : __________

Marital Status : S M D W Sex: M/F

Birthday : ________ / ________/ ________ Social sec:______ / _________/ ________

Home Phone: ( ) Work Phone: ( )

Emergency : _______________ Emer Phone : (________)________ ___

Email : _______________ Cell Phone : (________)________ ___

== Primary Insurance Coverage =============== Secondary Insurance Coverage ===============

Company : _______________ Company : _______________ ___

Insured Name :_______________ Insured Name:_______________

Relationship:__________DOB: :__________ Relationship:__________ DOB::__________

Co-pay amount: :__________ Co-pay amount :__________

Policy number:_______________ Policy number:_______________

Group number:_______________ Group number: :_______________

Employer :_______________ Employer: :_______________

======================== Guarantor Information==========================

Guarantor:____

Address: ____

State _______________ Zipcode:_______________

Telephone # : ( )

Patient's Authorization

I authorize OTTO ROZA MD PA to apply for benefits on my behalf for services rendered by OTTO ROZA MD PA. I request payment from my insurance company be made directly to OTTO ROZA MD PA. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or-any related claims. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided, when a statement is rendered.

____ _______________

Signature of Subscriber or Beneficiary Date