

# Marianne W. Rosen, M.D.

## PATIENT INFORMATION

(PLEASE PRINT)

DATE: \_\_\_\_\_

PATIENT'S NAME: \_\_\_\_\_ / \_\_\_\_\_  
(LAST) (FIRST) (MIDDLE) (PREFERRED NAME)

STREET ADDRESS: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_  
(CITY) (STATE) (ZIP)

BILLING ADDRESS: \_\_\_\_\_  
(IF DIFFERENT THAN ABOVE)

BIRTHDATE: \_\_\_\_\_ SEX: \_\_\_\_\_ SOCIAL SECURITY#: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ REFERRING PHYSICIAN: \_\_\_\_\_

MARITAL STATUS: MARRIED SINGLE OTHER

## SPOUSE/ PARENT INFORMATION

(IF MINOR OR STUDENT)

SPOUSE/ PARENT NAME: \_\_\_\_\_ SS#: \_\_\_\_\_

SPOUSE/ PARENT EMPLOYER: \_\_\_\_\_

SPOUSE/ PARENT WORK PHONE: \_\_\_\_\_

## INSURANCE INFORMATION

(COPY OF INSURANCE CARD IS REQUIRED)

PRIMARY INSURANCE: \_\_\_\_\_

INSURED'S FULL NAME: \_\_\_\_\_

INSURED'S BIRTHDATE: \_\_\_\_\_ INSURED'S SS# \_\_\_\_\_

SECONDAY INSURANCE: \_\_\_\_\_

INSURED'S FULL NAME: \_\_\_\_\_

INSURED'S BIRTHDATE: \_\_\_\_\_ INSURED'S SS# \_\_\_\_\_

## PATIENT QUESTIONNAIRE

1. Please list the family members or other persons, if any, whom we may inform about your general medical condition, your diagnosis, or discuss insurance/billing questions.

NAME:	PHONE#’S:	RELATIONSHIP:
_____	_____	_____
_____	_____	_____

2. Please print the telephone numbers where you want to receive calls about your lab and pathology results, or other health care information:

HOME #: \_\_\_\_\_

WORK#: \_\_\_\_\_

CELL#: \_\_\_\_\_

3. Can confidential messages (i.e. lab and pathology results etc.) be left on your home answering machine or voicemail? YES: \_\_\_\_\_ NO: \_\_\_\_\_

4. List telephone number(s) where appointment reminders can be left on an answering machine or voice mail. #: \_\_\_\_\_

#: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

\_\_\_\_\_  
PATIENT/ GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE

## CONSENT & MEDICAL RELEASE AUTHORIZATION

I, the undersigned patient or my authorized representative, hereby authorize my physician and whomever he/she may designate as his/her assistant to render my medical treatment to me. I consent to any medical care, which encompasses laboratory, diagnostic, or medical treatment, which my physician or his/her assistant may deem necessary during my office visit.

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_  
(PARENT IF MINOR)

I, the undersigned patient or my authorized representative, hereby authorize my physician and whomever he/she may designate as his/her assistant to release any medical information accumulated in the course of my examination and treatment to any other doctor, hospital, or other parties in assisting in my medical care.

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_  
(PARENT IF MINOR)

I, the undersigned patient or my authorized representatives, authorize the release of medical information and request payment of benefits to Marianne W. Rosen when they accept assignment. I understand I am responsible for any amount not covered by my insurance. I authorize use of a photostatic copy of this assignment in lieu of the original when necessary.

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_  
(PARENT IF MINOR)

## SOCIAL SECURITY ADMINISTRATION

**If you have health coverage through Medicare, please also sign this authorization:**

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries

or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C.3801-3812 provides penalties for withholding this information). Regulations pertaining to Medicare assignment of benefits also apply.

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_  
(PARENT IF MINOR)