MICHAEL DUCATO, M.D., P.C.
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ALL SECTIONS MUST BE COMPLETED OR INSURANCE CANNOT BE BILLED!

PATIENT INFORMATION

S.S.# _____ **NAME** _____
LAST FIRST MIDDLE INITIAL

ADDRESS _____ **DAYTIME PHONE** _____
NUMBER STREET CITY ZIP

BIRTH DATE _____ **SEX** _____ **EVENING PHONE** _____

EMPLOYER _____ **CELL PHONE** _____

EMERGENCY CONTACT: *(NOT AT YOUR RESIDENCE)* **EMAIL** _____

Name _____ Relationship _____ Phone _____

Address _____

INSURANCE INFORMATION:

Subscriber _____ Birth Date _____

Primary Insurance _____ Contract# _____ Group# _____

Subscriber _____ Birth Date _____

Secondary Insurance _____ Contract# _____ Group# _____

Subscriber _____ Birth Date _____

Third Insurance _____ Contract# _____ Group# _____

Due to the many changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible.

It is your responsibility to know your individual coverage.

Failing to comply with this suggestion could result in you, the patient, being responsible for all costs incurred. Please remember, your insurance policy is between you and your insurance company - and not with the insurance company and your doctor.

Signature X _____ Witness _____

I authorize the release of any medical information necessary to process my claim and request payment of medical benefits to MICHAEL DUCATO MD, PC

X _____ Date _____
SIGNATURE OF INSURED OR AUTHORIZED PERSON

Pharmacy Phone# _____ Pharmacy: _____

How did you hear about us?

❑ Website ❑ Google ❑ Ad ❑ Word of Mouth ❑ Insurance ❑ Other _____