Patient Registration

Mariano Busso, M.D., P.A.

Name: ______________________________ Date: ____________

Phone numbers to be contacted for appointments, results or to leave messages
Home ________________________ Cellular________________________

Business______________________ E-mail____

Patient____

Last Name First Name Middle Initial

Street Address____

City______________________________State______________________Zip______________

Sex: ___M ___ F Age_____ Birthdate______________ Single/ Married/ Widowed/ Separated/ Divorced

Social Security No.__________________________ Language Spoken______________________

Patient Employed By __________________________Occupation__________________________

Responsible party ____________________________Relationship to Patient________________

Social Security No ___________________________Date of Birth_______________________

Primary Insurance____

ID #_____________________Group # ____________Subscriber Name____________________

Secondary Insurance____

ID # ____________________Group #____________Subscriber # ______________________

Referred By ________________________________ Phone # ___________________________

Emergency Contact ___________________________ Phone # ___________________________

Family Doctor _______________________________ Phone # ___________________________

Please list any allergies you may have: ____

ASSIGNMENT AND RELEASE
The undersigned have insurance coverage with __________________________________
(Name of Insurance Company)

And assign directly to Dr. Mariano Busso all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Insurer/Guardian ______________________________ Date______________

MEDICARE AUTHORIZATION
I Request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Mariano Busso for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If “other health Insurance” is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature ___________________________________ Date ______________