Male	Female

PATIENT REGISTRATION

CELL NO: _____

MARITAL STATUS
S M W D SEP

NAME: _____ DATE OF BIRTH _____ AGE _____

STREET ADDRESS _____ PHONE (O) _____ (H) _____

CITY LAST

STATE ZIP _____ PHYSICIAN _____

OCCUPATION/ SPOUSE'S OCCUPATION

EMPLOYER _____ EMPLOYER _____

IF UNDER 18

SPOUSE'S NAME _____ PARENT/GUARDIAN _____

EMERGENCY CONTACT ADDRESS/

(OTHER THAN SPOUSE) _____ PHONE _____

SOCIAL SECURITY# _____ REFERRED BY _____

PAYMENT REQUESTED AT TIME OF SERVICE -UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE - NO WORKMAN'S COMP

I understand, I will be billed for all deductibles, and non covered service. I also agree to pay Dr. Damico if my Insurance Company doesn't pay within 45 days. I understand there will be a $10.00 service charge added to my bill for any unpaid copays not paid at the time of service.

PAYMENTS ☐ Check ☐ Cash ☐ Mastercard ☐ Visa

Do you have a deductible? ☐ Yes ☐ No

INSURANCE INFORMATION

INSURANCE NAME _____ EFFECTIVE DATE _____

SUBSCRIBER'S NAME _____ I.D.# _____ GROUP # _____ BENEFIT CODE _____

DO YOU HAVE OTHER INSURANCE? ☐ NO ☐ YES OTHER COVERAGE:

PETER J. DAMICO M.D.
6010 CURZON AVE., FORT WORTH, TX 76116

Assignment of insurance benefits/signature on file

I hereby authorize Dr. Peter J. Damico M.D. to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

I authorize use of this form on **all** my insurance submissions.
I authorize release of information to all my **Insurance Companies.**
I understand that **I am responsible** for my bill.
I authorize my doctor to act as **my** agent in helping me obtain payment from my Insurance Companies.
I authorize payment direct to my doctor.
I permit a copy of this authorization to be used in place of the original.

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf. I give general consent to treat. This consent shall remain in full force & effect until canceled by either party.

Patient Name (Please Print) _____ DL# _____

Parent/Guardian _____ Signature _____ Date _____

If you have an emergency after hours, call this office at 738-9268. Your call will be forwarded to Dr. Damico.

NO routine medications are filled on the weekend.