MARLENNY FELIZ MDPA

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PATIENT REGISTRATION

PATIENT NAME ____
Last First Initial

HOW DID YOU HEAR ABOUT US? ____

Home Address ____

City ________________ State ______ Zip __________ Date of Birth _________________

Mailing Address (if different) ____

Male/Female ___________ Social Security Number _________________ Marital Status ______

Home Phone ____________________________ Cell Phone______________________________

Employer ___________________ Occupation ________________ Telephone_______________

In case of emergence :

Name ________________________________ Relationship ______________________________

Address ______________________________ Telephone ________________________________

Medical Insurance Information:

1. Primary Insurance _______________________Policy Holder___________________________

DOB:_____________________________ SSN#:____

2. Secondary Insurance ______________________ Policy Holder ____________________

Name of Spouse or (if a minor) parent ____

Spouse's/Parent's Employer ________________________ Telephone _________________

Authorization and Assignment

I hereby authorize my insurance carrier, attorney or any third-party payer to pay directly Marlenny Feliz Cruz Internal Medicine all charges submitted for services incurred by me. I understand I will be responsible for any and all charges not paid by my insurance company. I authorize Marlenny Feliz Cruz Internal Medicine to release information concerning my medical condition to my insurance company, employer, hospital, physician or attorney for the purpose of processing a claim. I assign payment directly to the physicians at Marlenny Feliz Cruz Internal Medicine which may be due from the Medicare program or any other insurance company, including supplemental insurance, which may cover in whole or part medical services which I have received. The authorization and assignment shall be valid until I notify Marlenny Feliz Cruz Internal Medicine in writing of the cancellation. A photocopy of this authorization shall be valid as the original copy.

_______________________________ ________ __________________________ _________
Signature Date Signature (WITNESS) Date