Rafael R. Portela, M.D. – R. Antonio Portela, M.D.

Patient Information

Today's Date: _____

Patient's Name: _____ Date of Birth: _____ Age: _____
(Last) (First) (M.I)

Home Address: _____
(City) (State) (Zip Code)

Home Phone#: _____ Cell Phone#: _____ Work Phone#: _____

Sex: M ___ F ___ Marital Status: (Circle one) S M D W SSN#: _____

Race: _____ Ethnicity: _____ Primary Language: _____

Referring or Primary Care Physician: _____
(Name) (Phone)

Emergency Contact: _____ Relationship: _____ Phone# _____

Pharmacy

Name: _____ Telephone#: _____

Address: _____

Insurance Information

Primary Insurance:

Name of Insurance: _____ Policy I.D.#: _____

Group: _____ Insured's Name: _____ Sex: M____ F ____

SSN#: _____ Date of Birth: _____ Relationship to Patient: _____

Secondary Insurance:

Name of Insurance: _____ Policy I.D.#: _____

Group: _____ Insured's Name: _____ Sex: M____ F ____

SSN#: _____ Date of Birth: _____ Relationship to Patient: _____

Guarantor's Information

Mother's Name: _____ Date of Birth: _____

SSN#: _____ Work Phone#: _____

Father's Name: _____ Date of Birth: _____

SSN#: _____ Work Phone#: _____

LIFETIME INSURANCE AUTHORIZATION (NON-MEDICARE PATIENT)

I hereby authorize the release of any medical or other information necessary to process any claims. I also authorize payment of medical benefits to be sent directly to Rafael R. Portela, MD, R. Antonio Portela, MD.

Patient Signature: _____ Date: _____

I authorize any holder of medical or other information about me to release to the Social Security Admin. 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.

Patient Signature: _____ Date: _____

FINANCIAL RESPONSIBILITY STATEMENT

I understand that I am financially responsible for payment of any medical services to Rafael R. Portela, MD, R. Antonio Portela, MD, regardless of any insurance benefits that I might have. I also understand that it is my responsibility to collect any reimbursement from my insurance company. I understand that I will be responsible for any fees that might be incurred by Rafael R. Portela, MD, R. Antonio Portela, MD, in their efforts to collect fees due to them, including fees, bur not limited to collection agencies, attorney's fees and court costs.

Patient Signature: _____ Date: _____