Please Print

Date:_____

Date of Birth_____( )Male ( ) Female Marital Status_____

Name (as shown on insurance card)_____

Address_____City_____State_____Zip _____

Cell Phone_____ Home Phone_____

E-Mail_____ Primary Care Dr_____

Emergency Contact Name_____ Phone #_____

Social Security #_____-_____-_____ Employed ( )Yes ( )No

INSURANCE

Primary Insurance Name and Address_____

Policy or ID#_____ Group #_____ Effective Date_____

Policy Holder Name if different than Patient_____

SSN#_____-____-_____ Date of Birth_____ Relationship_____

Secondary Insurance Name and Address_____

Policy or ID#_____ Group #_____ Effective Date_____

Policy Holder Name if different than Patient_____

SSN#_____-____-_____ Date of Birth_____ Relationship_____

Insurance Assignment, Release of Information and Financial Disclosure

I hereby assign Dr Charles Schaffer DBA Placido LLC payment from my insurance for services rendered. I understand that I am financially responsible for all charges, whether they are paid by insurance or not. I authorize the doctor's staff to release all necessary information to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signanture of Patient or Guardian

I hereby authorize Dr Charles Schaffer DBA Placido LLC to release information acquired during the course of my examination or treatment to my referring physician, my primary care doctor or to an appropriate insurance carrier. If a Medicare patient, I further authorize release to the Center for Medicare Services and its agents any information needed to determine benefits payable for related charges.

Signature of Patient or Guardian