DR. DONATELLO

PLEASE PRINT CLEARLY

PATIENT INFORMATION

Patient Name_____Sex_____Date of Birth_____

Address_____City_____State____Zip_____

Home Phone_____Social Security Number_____Martial Status_____

Employer_____Work Phone_____

Address_____City_____State____Zip_____

Emergency Contact_____Relationship_____Phone_____

PERSON RESPONSIBLE FOR PAYMENT, GUARANTOR (if different from above)

Patient Name_____Sex_____Date of Birth_____

Address_____City_____State____Zip_____

Home Phone_____Social Security Number_____Relationship to Patient_____

Employer_____Work Phone_____

Address_____City_____State____Zip_____

Referred To This Office By_____

CONSENT FOR TREATMENT, RELEASE AND ASSIGNMENT AUTHORIZATIONS

I hereby give Dr. Donatello and his associates my consent to perform the procedures that may be necessary for medical evaluation and treatment.

I hereby authorize you to release portions of my medical records and/or medical information to my health insurer for the purpose of processing medical claims. This authorization will remain in effect until revoked by me in writing.

I hereby authorize you to bill my health insurer on my behalf for services provided by Dr. Donatello and his associates and assign payment of benefits for payment of such claims directly to Dr.Donatello. I understand that I am responsible for payment of any balance not paid by my insurer, including claims for services not covered by my insurer and any claims that are applied to my deductible. A photocopy of this draft may be used in place of the original.

Signature_____

Relationship_____Date_____

Method of Payment: Cash Check Visa MC