JOSEPH R. RACCUGLIA, MD, LLC
PATIENT DEMOGRAPHICS – Page 1

NEW PATIENT / REVISION (Circle One) **DATE:**_____

NAME:_____DOB:_____

SOCIAL SECURITY NUMBER:_____ MALE/FEMALE

RACE: (please circle one)

White	Asian
Native Hawaiian or other Pacific Islander	Black or African American
American Indian or Alaska Native	Not Provided

ETHNICITY: (please circle one)

Hispanic or Latino	Not Hispanic or Latino	Not Provided

LANGUAGE: (please circle one)

English	French	German
Greek	Ibo	Italian
Japanese	Latvian	Mandarin
Russian	Spanish	

ADDRESS:

STREET:_____

CITY:_____STATE:_____ZIP:_____

PHONE: (HOME)_____(WORK)_____

(CELL)_____ EMAIL:_____

RESPONSIBLE PARTY INFORMATION – IF DIFFERENT FROM ABOVE

NAME:_____RELATIONSHIP TO PATIENT:_____

SOCIAL SECURITY NUMBER:_____ MALE/FEMALE

ADDRESS:

STREET:_____

CITY:_____STATE:_____ZIP:_____

PHONE: (HOME)_____(WORK)_____

(CELL)_____ EMAIL:_____

RELEASE AND ASSIGNMENT:

I HEREBY ASSIGN ALL MEDICAL AND/OR SURGICAL BENEFITS TO INCLUDE MAJOR MEDICAL BENEFITS TO WHICH I AM ENTITTLED INCLUDING MEDICARE, BLUE SHIELD, HMOS AND COMMERCIAL INSURANCE TO JOSEPH R. RACCUGLIA, MD, LLC.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES THAT ARE NOT COVERED BY MY DESIGNATED INSURANCE(S).

I ACCEPT RESPONSIBILITY FOR ACCRUING INTEREST AS WELL AS THE FEES AND/OR LEGAL COSTS ASSOCIATED WITH THE COLLECTION OF MY ACCOUNT SHOULD IT BECOME DELINQUENT. I HEREBY AUTHORIZE SAID ASSIGNEE TO RELEASE ANY INFORMATION NECESSARY TO SECURE PAYMENT ON MY BEHALF.

PATIENT NAME:_____

RESPONSIBLE PARTY NAME (if different):_____

RESPONSIBLE PARTY SIGNATURE:_____

DATE:_____