BF MD

Name:_____

Date of Birth:___/___/___ Age:_____

Social Security Number:_____

Male [ ] Female [ ]

Home Phone:_____ Cellular Phone:_____

Work Phone:_____ E-Mail Address:_____

******* Please note if we should not use any of the numbers to contact you*******

Address: _____

City:_____ State:_____ Zip Code:_____

Employed By:_____ Occupation:_____

Spouse / Parent : _____ Work Number:_____

Employed By:_____ Occupation:_____

Emergency Contact:_____ Phone Number:_____

Primary Care Physician:_____ Phone Number:_____

Who Referred You To This Office:_____

I, the undersigned, have insurance coverage with _____ and assign directly to Dr's Barry and Coleene Fernando, all surgical and/or medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits.

Signed by Patient/Guardian:_____Date:_____