ITALIAN
PLEASE ANSWER IN ENGLISH

# BAYVIEW GENERAL MEDICINE

**TELEFONO CACA_____**

**DATA_____** **CELL PHONE_____**

**PAZIENTE_____**

**RESPONSABILE (SE MINORE) _____**

**UIA_____**

**CITTA_____STATO_____ZIP_____**

**SESSO ( ) MALE ( ) FEMALE ETA_____ DASA DI NASARA_____**

**SPOSATA _____ SOLO _____ VEDOVA _____ SEPARATA _____DIVORZIATA_____**

**DATORE DI CAVORO E NUMERO DEL PAZIENTE_____**

**DEL CONIUGE_____**

**MOTIVO DELIA VISTITA_____**

**WHO IS RESPONSIBLE FOR ACCOUNT_____**

**RELATIONSHIP TO PATIENT_____**

**SOCIAL SECURITY #_____**

**COME INTENOL PAGARE _____CONTANTI_____MC/VISA_____AMEX**

**HAI UN ASSICUVZAZIONE MEDICA_____NO_____ SI (IF SI)**

**NOME DELLA PRIMA ASSICURAZIONE_____**

**NOME DELLA SECONDARIA ASSICURAZIONE_____**

**IN CASO DI EMERGENZA AVVERTIRE_____NUMERO DE TELEPHONO_____**

**HOW DID YOU LEARN OF OUR PRACTICE_____**

**EMAIL ADDRESS_____**

**The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself or my dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim. I _____hereby authorize _____ to pay and hereby assign directly to Richard W Blanchar M.D. all benefits, otherwise payable to me for his services as described on the attached forms. I understand that I am financially responsible when received by and paid to_____ will be credited to my account, in accordance with the above said assignment.**

**SIGNATURE_____ DATE_____**

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