

## JOSEPH TERRACINA, M.D.

### NEW PATIENT INFORMATION:

|                          |                         |                         |                 |
|--------------------------|-------------------------|-------------------------|-----------------|
| Full Name:               |                         | Social Security Number: |                 |
| Date of Birth:           | Age:                    | Sex:                    | Marital Status: |
| Address:                 | City:                   | State:                  | Zip:            |
| Phone:                   | Cell:                   |                         |                 |
| Driver's License Number: | Pharmacy:               |                         |                 |
| Referring Physician:     | Primary Care Physician: |                         |                 |
| Employer:                | Work Phone:             |                         |                 |
| Employer Address:        |                         |                         |                 |

### SPOUSE/PARENT INFORMATION:

|                         |                |               |      |
|-------------------------|----------------|---------------|------|
| Name:                   |                | Relationship: |      |
| Social Security Number: | Date of Birth: | Phone:        |      |
| Address:                | City:          | State:        | Zip: |
| Employer:               | Work Phone:    |               |      |
| Employer Address:       |                |               |      |

### ADDITIONAL GUARDIAN/GUARANTOR INFORMATION

|                         |                |               |      |
|-------------------------|----------------|---------------|------|
| Name:                   |                | Relationship: |      |
| Social Security Number: | Date of Birth: | Phone:        |      |
| Address:                | City:          | State:        | Zip: |
| Employer:               | Work Phone:    |               |      |
| Employer Address:       |                |               |      |

### EMERGENCY CONTACT:

|        |  |               |  |
|--------|--|---------------|--|
| Name:  |  | Relationship: |  |
| Phone: |  | Cell:         |  |

### INSURANCE INFORMATION

*WE WILL NEED A COPY OF YOUR INSURANCE CARD(S) AND DRIVER'S LICENSE FOR OUR FILES.*

|                                |         |                                |         |
|--------------------------------|---------|--------------------------------|---------|
| Primary Insurance:             |         | Secondary Insurance:           |         |
| Mail Claims To:                |         | Mail Claims To:                |         |
| Group No.                      | ID No.: | Group No.                      | ID No.: |
| Policy Holder's Name:          |         | Policy Holder's Name:          |         |
| Relationship to Patient:       |         | Relationship to Patient:       |         |
| Address:                       |         | Address:                       |         |
| City, St., ZIP:                |         | City, St., ZIP:                |         |
| Policy Holder's Date of Birth: |         | Policy Holder's Date of Birth: |         |
| Policy Holder's Soc. Sec. No.: |         | Policy Holder's Soc. Sec. No.: |         |
| Policy Holder's Employer:      |         | Policy Holder's Employer:      |         |

### AUTHORIZATION TO TREAT MY CHILD (IF APPLICABLE)

List below any persons that you give permission to accompany your child for medical treatment (other than parent or guardian)

| Name | Relationship to You | Telephone No. |
|------|---------------------|---------------|
|      |                     |               |

### AUTHORIZATION, CONSENT AND ACKNOWLEDGMENT

I hereby authorize my insurance benefits to be paid directly to Joseph Terracina, M.D. I consent to the use or disclosure of my protected health information by Joseph Terracina, M.D. for the purpose of diagnosing and providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of Joseph Terracina, M.D. I have the right to revoke this consent in writing at any time, except to the extent that Joseph Terracina, M.D. has taken action on reliance of this consent. The Notice of Privacy Practices for Joseph Terracina, M.D. has been provided to me.

Signature of Patient or Guardian

Date