Thomas A. Graziano, MD, DPM, FACFAS

Welcome to our Office... ***visit us on the web at*** *www.drtgraziano.com*

Social Security#			
First Name:		**Last Name:**	
Middle Initial:		**Date of Birth:**	/ /
Gender:	☐ Male ☐ Female	**Marital Status:**	☐ Single ☐ Married ☐ Other
Street Address:		**CITY:**	
STATE:	**ZIP:**	**Employer Name:**	
Home Phone:		**Emergency Contact:**	
Work Phone:		**Emergency Telephone#:**	
Cell Phone:		**Primary Care Physician:**	
Reason for today's Visit:		Who referred you to our office:	

Primary Insurance Company Information:	**Secondary Insurance Company Information:**
Policy Holder Information	**Policy Holder Information**
First Name: _____	**First Name:** _____
Last Name: _____	**Last Name:** _____
Policy Holders SS# _____-_____-_____	**Policy Holders SS#** _____-_____-_____
Policy Holders Date of Birth: _____	**Policy Holders Date of Birth:** _____
Relationship to Policy Holder: ☐Self ☐Spouse ☐Child ☐Other	**Relationship Policy Holder:** ☐Self ☐Spouse ☐Child ☐Other
Gender: ☐ Male ☐ Female	**Gender:** ☐ Male ☐ Female
Address: _____	**Address:** _____
City: _____ **State:** _____ **Zip:** _____	**City:** _____ **State:** _____ **Zip:** _____
Insurance's Name: _____	**Insurance's Name:** _____
Policy ID: _____	**Policy ID:** _____
Group# _____	**Group#** _____
Address: _____	**Address:** _____
Effective Date: _____	**Effective Date:** _____
Do you have a Co-pay? Yes **Amt $** _____ or NO	**Do you have a Co-pay?** Yes **Amt $** _____ or NO

I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND HEREBY ASSIGN TO THE PHYSICIAN ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MY DEPENDENTS OR MYSELF. I UNDERSTAND THAT IT IS AS A COURTESY THAT THE DOCTOR ACCEPTS MY INSURANCE FOR PAYMENT AND THAT IF FOR ANY REASON THEY DO NOT PAY MY BILL THAT I AM RESPONSIBLE.

Date:_____ Patient's Signature: _____

PLEASE FOLD THIS PAGE UP FILL IN REQUESTED INFORMATION