B. J. Anarumo, D. O., P.A.

Patient History

All Information must be completed - **PLEASE PRINT CLEARLY**

DATE: _____

CHILD'S NAME: _____ Date of Birth: _____ Male___ Female ___
Last First Middle Month / Day / Year

Child's Soc Sec #_____ Reason for visit: _____

Address: _____
Street Apt. City State Zip

Home Phone: _____ Alternate Phone: _____ E-mail: _____

Father's Name: _____ Mother's Name: _____

Date of Birth_____ Date of Birth_____

Soc Sec #: _____ Soc Sec #: _____

Parent's Marital Status: _____Single _____ Married _____ Widowed _____ Separated _____ Divorced

Guardian (if any) _____

Who should be notified in case of an emergency? _____
Name Phone #

Father's Occupation: _____ Mother's Occupation:_____

Employer: _____ Employer: _____
Name Phone Name Phone

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Name of Insurance Company: _____ ID# _____

Name of Insured: _____ Group # _____

Secondary Insurance: _____ID#_____Group #_____

Medicaid 10 digit ID #_____ Medicaid Gold Card # _____

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Referred by: _____ Relative _____ Friend _____ Other_____

Last visit to a physician: _____
Name of Doctor Date of Visit Reason for Visit

Has the Child had: Heart trouble Y N Rheumatic Fever Y N Diabetes Y N Asthma Y N Tuberculosis Y N Convulsions Y N

Allergic reactions to drugs? _____ Allergic reaction to Anesthesia? _____

Preferred Pharmacy Name:_____ Phone #_____

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If you have more than one child, please list their names and dates of birth :

1._____ 4._____

2. 5.

3._____ 6._____

B.J. ANARUMO, PA, DO
18308 Murdock Circle, Unit 103
Port Charlotte, FL 33948
941-629-3618 629-9809 Fax

Consent: I consent to physician examination, laboratory procedures, medical diagnostic and therapeutic procedures and other services rendered under general and specific instructions of the physician and physician's staff under the direction and supervision of the physician.

Release Of Information: It is agreed that all records concerning the patient's visit remain the property of the physician's office and the physician. All office staff who require information from the record for intervention are authorized to view such. I authorize the physician, pursuant to proper authorization or court order, to disclose all or any part of my medical record to any person or corporation which is or may be liable to the physician, to the patient or to a family member of the patient, the Social Security Administration, and the Florida Department of HRS, its intermediaries or carries for all or part of the physician's charges.

Assignment of Insurance Benefits: I request that payment of authorized insurance benefits be made on my behalf to the provider indicated for any services furnished me. I understand that I am responsible for any health insurance deductible and co-insurance not otherwise covered.

A photocopy of this form is to be considered as valid as the original until revoked.

The undersigned certifies that he/she has read and understands the foregoing, and is the patient, the patient's parent, or legal guardian or is duly authorized as the patient's general agent to execute the above and accept its terms for a period of up to one year.

I request that the above acknowledgment be in effect for **ONE YEAR FROM THE DATE OF THIS DOCUMENT** for physician and diagnostic services rendered.

*******EFFECTIVE 1/1/07******
THERE WILL BE A $25.00 FEE FOR
ALL RETURNED CHECKS
NO other CHECKS will be accepted---future payments must be made by either CASH or CREDIT CARD

***Appointment No Shows & Cancellations made with less than 24 hour notice may be subject to a $25.00 fee which will be billed to YOU not your insurance company.**

****This practice reserves the right to DISMISS patients who fail to cancel their appointments with less than 24 hour notice, or fail to show for their appointments.****

Signed on behalf of the patient: _____Date:_____

Relationship to patient;_____

Witness Signature: _____

1/07

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INSURANCE & BILLING INFORMATION

Because Dr. Anarumo participates in many managed care plans, it is difficult to keep up to date with the requirements and changes pertaining to each. During your visit to our office, we will call your insurance company to verify coverage. However, this does not guarantee that your insurance company will cover the services that we will provide.

We encourage you to become familiar with your insurance provider's requirements, given that failure to do so may cause you unnecessary or unexpected out-of-pocket expenses. For instance, if you are a part on an HMO plan, you may need a referral, an authorization, or both, by your primary care provider, before your plan will cover any expenses that incur for treatment that is rendered. Additionally, some plans will only cover expenses that incur after you have paid a "deductible".

Please note that we collect for our services at the time that services are rendered. Although we will be happy to bill your insurance company on your behalf we still hold our patients financially responsible for the services that we provide.

We look forward to establishing a good rapport with you, therefore, we welcome any questions that you may have about our fees or about insurance coverage and will answer them to the best of our ability.

_____ _____

Signature Date

1/07