ROMANICK MD PLLC
arthritis, fibromyalgia & immune disorders

Personal Information			
Last name	First Name	MI	
Address			
City		State	Zip
Home phone	Cell	Email	
Date of Birth	Gender M F	Social Security Number	Marital Status
Spouse's Name	Employer (or student status)	Work Phone	
Allergies	I give permission for test results to be left on/with: (circle where applicable) Home phone Cell Spouse email other individual (specify):		

Insurance Information		
	Primary Insurance	Secondary Insurance
Insurance Name		
Subscriber's Name		
Subscriber's Birth Date and sex: M or F		
Relationship to subscriber: child, spouse, self, other		
Policy Number		
Group, Member or Claim Number		
Effective Date		
Co-payment Amount		

Emergency Contact		
Name	Relationship	Phone Number

Referred to this office by:

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. I further agree that a photocopy of this agreement shall be as valid as the original. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance, including no show visits and late cancellations (a copy of the no show / cancellation policy is included in your new patient packet and is also available from the receptionist).

Patient Signature Date