MARK A. PINTO MD INC, RESIDENTIAL VISITS PRACTICE

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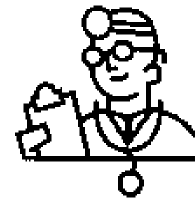

NEW PATIENT ENROLLMENT FORM

NEW PATIENT INFORMATION

PATIENT'S NAME (LAST, FIRST MI)	DATE OF BIRTH
PATIENT'S SOCIAL SECURITY NUMBER	ROOM NUMBER
FACILITY NAME	FACILITY PHONE NUMBER

INSURANCE INFORMATION
SEND A COPY OF MEDICARE & SECONDARY INSURANCE CARD WITH THIS FORM

MEDICARE NUMBER (YOU MUST HAVE MEDICARE PART B COVERAGE)			
SECONDARY INSURANCE	POLICY NUMBER	GROUP NUMBER	
NAME OF POLICY HOLDER OF SECONDARY INSURANCE		RELATIONSHIP	
NAME OF PERSON FINANCIALLY RESPONSIBLE FOR PATIENT		RELATIONSHIP	
ADDRESS	CITY	ST	ZIP
WORK PHONE	HOME PHONE	USE AS EMERGENCY CONTACT	
		☐YES ☐NO	

PHYSICIAN INFORMATION

CURRENT PRIMARY CARE PHYSICIAN		PHYSICIAN'S PHONE NUMBER	
ADDRESS	CITY	ST	ZIP
MEDICAL POWER OF ATTORNEY	*NAME	*RELATIONSHIP	
☐ PATIENT ☐ OTHER*			
MY HOSPITAL OF CHOICE IS ...			

I understand that MARK A. PINTO MD INC, RESIDENTIAL VISITS PRACTICE DOES NOT ACCEPT Medicare HMOs and that I will be financially responsible for payment of service if Medicare denies payment due to my participation in an HMO program. I also will be responsible for payment if I choose to cancel Medicare Part B coverage. I further understand that MARK A. PINTO MD INC. will not scheduale patients until all insurance is verified.

I hereby assign the attending physician any payable to me under hospitalization or other insurance coverage, and/or other arrangements with third parties, for payment of such services. I also agree to be responsible for any testing or treatment that may not be considered by my insurance company to be medically

Signature Date