**NARCISA A. DUSA, MD**
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# Patient Information

| | | | | |
|---|---|---|---|---|
| First Name: | MI: | Last Name: | | Nickname: |
| Address: | City: | | State: | Zip: |
| | DOB: | | SSN: | |
| | *Email:* | | | |
| *Phones* Home: | Cell: | | Work: | |
| Did someone refer to us: | | | | |
| Preferred Pharmacy: | | | | |

| **EMERGENCY CONTACT INFO** | |
|---|---|
| Spouse: | Phone #s: |
| Relative: | Phone #s: |
| Friend: | Phone #s: |

| **PRIMARY INSURANCE** | | |
|---|---|---|
| Insurance Name: | | Type(HMO/PPO/POS/etc): |
| Insurance Address: | | |
| Group #: | | Effective Date: |
| Insured SSN: | | Insured DOB: |
| Insured First Name: | Last Name: | |
| Relationship to Patient: Self: _ Spouse: _ Parent: _ Guardian: _ Other (please specify):_____ | | |

| **SECONDARY INSURANCE** | | |
|---|---|---|
| Insurance Name: | | Type(HMO/PPO/POS/etc): |
| Insurance Address: | | |
| Group #: | | Effective Date: |
| Insured SSN: | | Insured DOB: |
| Insured First Name: | Last Name: | |
| Relationship to Patient: Self: _ Spouse: _ Parent: _ Guardian: _ Other (please specify):_____ | | |

## ASSIGNMENT AND RELEASE

I certify that I and/or my dependent/s have insurance coverage with the Insurance Company or Companies specified above and directly assign to **Narcisa A. Dusa, MD**/Hearst Medical all insurance benefits, that are payable to her for services rendered. I understand that I am financially responsible for all charges whether or not they are paid by insurance. I authorize the use of my signature on all insurance claims. My signature is valid even this form is photocopied. **Dr. Dusa** can use my personal healthcare information and may disclose such information to the above-named Insurance Company or Companies and their agents for obtaining payment for services and determining insurance benefits payable for related services. This assignment of benefits will remain in effect until revoked by me in writing.

_____ _____
Signature of Patient, Spouse, Parent, Guardian or Personal Representative Date