# ELIZABETH A. LIOTTA, MD, LLC

## NEW PATIENT INFORMATION

(Please Print Clearly)

**Date:** ______________

## Patient Information

| Last Name | First Name | MI | Patient's Social Security Number |
|---|---|---|---|
| Address (Street) | | | DOB / Sex (M/F) |
| City | State | Zip | Home Phone |
| Cell Phone | Work Phone (Ext) | | Email |
| Emergency Contact | | | Emergency Phone |
| Referring Physician | | | Phone |

## Insurance Information

| **Primary Insurance Company** | Group No. | Policy ID No. |
|---|---|---|
| Policy Holder's Name | DOB | Relationship to Patient |
| Policy Holder's Employer | | Co-Pay Amount |
| **Secondary Insurance Company** | Group No. | Policy ID No. |
| Policy Holder's Name | DOB | Relationship to Patient |
| Policy Holder's Employer | | Co-Pay Amount |

## Guarantor Information (For Minors)

| **Guarantor's Name** | | | SSN |
|---|---|---|---|
| Address (Street) | | | Home Phone |
| City | State | Zip | Work Phone |

## Patient's Authorization

I authorize ELIZABETH A. LIOTTA, MD to apply for benefits on my behalf for services rendered by ELIZABETH A. LIOTTA, MD. I request payment from my insurance company be made directly to ELIZABETH A. LIOTTA, MD. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claims. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing. I understand that nothing herein relieves me of my primary responsibility and obligation to pay for medical services provided, when a statement is rendered.

| **Patient (or Minor Patient's Representative) Signature** | **Date** |
|---|---|
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