EILEEN C. COMIA, M.D. LLC	DATE	NEW ☐ UPDATE ☐
PRIMARY CARE PROVIDER	PHARMACY NAME	
REFERRED BY	PHARMACY PHONE	
	HIPAA AUTHORIZATION CODE	

PATIENT INFORMATION

Acct Number

LAST	FIRST	MI.	BIRTHDATE	SEX M ☐ F ☐
ADDRESS	CITY	STATE ZIP		MARITAL STATUS
HOME PHONE	WORK PHONE			
CELL PHONE	EMAIL ADDRESS			
PATIENT SOCIAL SECURITY #	Preferred Contact Phone			
RACE ❑ AMERINDIAN ❑ BLACK ❑ HISPANIC ❑ ASIAN ❑ WHITE				
ETHNICITY ❑ HISPANIC ❑ NON-HISPANIC	PREFERRED LANGUAGE:			
EMPLOYER/SCHOOL	OCCUPATION			
EMPLOYER'S ADDRESS	CITY	STATE ZIP	START DATE	
NEXT OF KIN/EMERGENCY CONTACT (PERSON NOT LIVING WITH YOU)	RELATIONSHIP	PHONE		

PARENT/GUARANTOR INFORMATION- PERSON FINANCIALLY RESPONSIBLE FOR BILL

LAST	FIRST	MI.	❑ PARENT (IF PATIENT A MINOR) ❑ SPOUSE ❑ OTHER _____	BIRTHDATE
ADDRESS (IF DIFFERENT FROM PT.)	CITY	STATE ZIP		SOCIAL SECURITY #
HOME PHONE	WORK PHONE	CELL PHONE	EMAIL ADDRESS	
EMPLOYER/SCHOOL	OCCUPATION			
EMPLOYER'S ADDRESS	CITY	STATE ZIP	START DATE	

INSURANCE INFORMATION

Please complete all information to ensure accuracy in claim submission

INSURANCE COMPANY #1	POLICY/MEMBER ID #	GROUP #	COPAYS SPEC - $ PRIM - $
POLICY HOLDER	ADDRESS (IF DIFFERENT)	SSN	RELATION TO INSURED ❑ SELF ❑ SPOUSE
DOB	CITY ST ZIP		❑ CHILD ❑ OTHER
INSURANCE COMPANY #2	POLICY/MEMBER ID #	GROUP #	COPAYS SPEC - $ PRIM - $
POLICY HOLDER	ADDRESS (IF DIFFERENT)	SSN	RELATION TO INSURED ❑ SELF ❑ SPOUSE
DOB	CITY ST ZIP		❑ CHILD ❑ OTHER

INJURY INFORMATION

IS INJURY ❑ WORK RELATED ❑ AUTO RELATED CLAIM #_____ DATE OF INJURY

I, THE PATIENT OR GUARANTOR, CERTIFY THAT THE INFORMATION ON THIS FORM IS TRUE TO THE BEST OF MY KNOWLEDGE. I ACCEPT RESPONSIBILITY FOR THE MEDICAL CHARGES INCURRED BY THE PATIENT AND AGREE TO PAY ALL BILLS AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS ARE MADE. I AUTHORIZE PHYSICIAN AND PRACTICE TO RELEASE ANY INFORMATION TO PROCESS INSURANCE CLAIMS. I ALSO AUTHORIZE MY INSURANCE CLAIMS TO BE PAID DIRECTLY TO THE PRACTICE OR ITS REPRESENTATIVE. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO CONTACT BY INSURANCE AND PRIMARY CARE PROVIDER TO ENSURE THAT ANY REQUIRED REFERRALS ARE INITIATED. I UNDERSTAND THAT ALL SERVICES NOT COVERED BY MY INSURANCE WILL BE MY RESPONSIBILITY.

PATIENT/GUARANTOR SIGNATURE _____ ***DATE*** _____

(PARENT IF PATIENT IS A MINOR)