ANTONIO ROSADO, M.D., FACC, FACC
4302 Alton Road, Suite 470
Miami Beach, FL 33140
Phone: 786 709-5865 Fax: 305 397-8889

Patient Information

Today's Date: _____ /_____ /_____

Last Name: _____ First:_____ Middle I:_____ Mr./Mrs./Miss./Ms.

Birth Date: ___/____/____

Is this your legal name _____ if not, what is your legal name?_____ Former Name:_____

Street Address: _____ City:_____ ST:_____ Zip_____

Social Security: _____ Home Phone: ( )_____ Cell: ( )_____

(If applicable): P.O. Box_____ City:_____ ST:_____ Zip:_____

Occupation: ( )_____ Employer:_____ Employer Phone:( )_____

Other family seen here: _____

Insurance Information

(PLEASE GIVE INSURANCE CARD TO RECEPTIONIST)

Person responsible for bill_____ D.O.B.:_____ Home Phone: _____

Address: _____ Is the person a patient here: Y/N Occupation:_____

Employer:_____ Employer Address:_____ Employer Phone: _____

Primary Insurance: _____

Subscriber name:_____ Social Security:_____ D.O.B._____

Policy Number:_____ Group_____ Co-pay_____

Patients relationship to subscriber: Self/ Spouse/ Child/ Other

Secondary Insurance Information:

Name of Secondary (If applicable): _____ Subscriber Name: _____

Policy ID:_____ Group ID:_____

Patients relationship to subscriber: Self/ Spouse/ Child/ Other

IN CASE OF EMERGENCY

Name of local friend or relative_____ Relationship to patient:_____
(Not living at the same address)

Home Phone: _____ Work Phone:_____ Cell:_____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Antonio Rosado, M.D. or the insurance company to release any information required for the processing of my claims.

Patient/ Parent or Guardian: _____ Date:_____