ANTHONY C. QUARTELL, M.D. & ASSOCIATES
Anthony C. Quartell,M.D.,F.A.C.O.G.,F.A.C.S.,

TODAY's DATE: __________ I am a patient of: DR. Quartell Kelly Calleros, NP PHARMACY PHONE # :______________________

( at least one of above must be circled )

PATIENT LAST NAME: ______________________ First :______________________ MI:________ Date of Birth:__________ Age:____

Address: ______________________ City:______________________ State: __________ zip code: ______________

Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________ email: ______________

Social Security: ______________ Referred by: ______________________ Status: ___Married ___Single __Divorced __Widowed

Emergency Contact: ______________________________ Telephone: (H)______________ (C) ______________

Spouse's Name: ______________________ Date of Birth: ______________ Social Security: ______________

How were you referred to our office: (circle one) Another physician Internet Person Insurance other:______________

Name of physician or person who referred you:__________________________________________

PATIENT'S EMPLOYER: ______________________ OCCUPATION: ______________ TELEPHONE: ______________

PATIENT'S BUSINESS ADDRESS: ______________________________ STATE : __________ ZIP CODE: ______________

SPOUSE"S EMPLOYER: ______________________ OCCUPATION: ______________ TELEPHONE: ______________

SPOUSE"S BUSINESS ADDRESS: ______________________________ STATE: __________ ZIP CODE: ______________

INSURANCE INFORMATION

PRIMARY INSURANCE: ______________________ ID #:______________ CO-PAY: ______________

SUBSCRIBER NAME: ______________________ Date of Birth:______________ SS #: ______________

SECONDARY INSURANCE : ______________________ ID #: ______________ CO-PAY: ______________

SUBSCRIBER NAME: ______________________ Date of Birth: ______________ SS #______________

DUE TO INSURANCE TIMELY FILING RULES, I UNDERSTAND THAT I AM RESPONSIBLE FOR FULL PAYMENT IF I DO NOT PROVIDE ACCURATE INSURANCE INFORMATION AT THE DATE OF SERVICE OR WITHIN THREE BUSINESS DAYS OF MY VISIT. I ALSO UNDERSTAND THAT I AM RESPONSIBLE FOR ANY NON COVERED SERVICES CHARGED BY THIS FACILITY OR ANY FACILITY I AM REFERRED TO. IT IS UP TO ME TO CHOOSE the SPECIFIC LABORATORY OR OTHER FACILITY OR PROVIDER FOR ANY SERVICES AC QUARTELL REFERS ME. I AM AWARE THAT MY INSURANCE MAY REQUIRE SPECIFIC PROVIDERS AND IT IS UP TO ME TO KNOW THIS.

______________________________________ SIGNATURE

___ I AUTHORIZE USE OF THIS CONSENT FOR ALL INSURANCE SUBMISSIONS.

___ I AUTHORIZE RELEASE OF MY MEDICAL FILE AND OTHER RELEVANT INFORMATION TO MY INSURANCE CARRIERS.

___ I AUTHORIZE MY DOCTOR TO ACT AS MY AGENT IN HELPING ME OBTAIN PAYMENTS FROM MY INSURANCE COMPANIES.

___ I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.

___ I AUTHORIZE PAYMENT DIRECTLY TO MY DOCTOR. ________ I UNDERSTAND THAT I AM RESPONSIBLE FOR MY BILL.

___ I AUTHORIZE MESSAGES TO BE LEFT ON MY VOICE MAIL.

______________________________________ SIGNATURE

ANTHONY C. QUARTELL M.D. & ASSOCIATES HAS MADE AVAILABLE TO ME THEIR "NOTICE OF PRIVACY PRACTICES" (Eff 4/03)

______________________________________ SIGNATURE

ATIENTS UNDER 18 YEARS OF AGE: CHECK ONE AND SIGN:

___ I DO I DO NOT AUTHORIZE DISCLOSURE OF MEDICAL INFORMATION TO MY PARENT(S) or LEGAL GUARDIAN(S).

______________________________________ SIGNATURE