

PIGA PRIMARY CARE ASSOCIATES

Specialists in Adult and Pediatric Medicine

Jonathan C Piga, MD
Naomi C Piga, MD FAAP
Versallie R Capote-Piga, MD FAAP



Patient Demographic Information

Patient Name _____

Gender _____ Date of Birth: _____ Marital Status: _____

Social Security #: _____ Driver License #: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Cell Phone #: _____

Employer Name: _____

Employer Address: _____

City: _____ State: _____ Zip Code: _____

Work Phone #: _____ Position: _____

For pediatric patients only: Information regarding Parent/Guardian/Legal Representative

Mother's Name _____

Date of Birth: _____

Social Security #: _____ Driver License #: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Cell Phone #: _____

E-mail Address: _____

Employer Name: _____ Work Phone #: _____

Father's Name _____

Date of Birth: _____

Social Security #: _____ Driver License #: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Cell Phone #: _____

E-mail Address: _____

Employer Name: _____ Work Phone #: _____

Billing Responsibility: (Circle One) *Father Mother Other*

Name if Other: _____

Date of Birth: _____ Relationship to Patient _____

Social Security #: _____ Driver License #: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Cell Phone #: _____

Emergency Information

Emergency Contact Name: _____ Phone #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

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Insurance Information *Please skip if you have no insurance coverage*

Insurance Company: _____ Phone #: _____
Claims Mailing Address: _____
City: _____ State: _____ Zip Code: _____
Policy #: _____ Group #: _____
Effective Date: _____
Name of Primary Insured: _____
Primary Insured Date of Birth: _____ Social Security #: _____

Preferred Pharmacy Information *Pharmacy on file for medications and refills*

Name: _____ Phone #: _____
Address: _____
City: _____ State: _____ Zip Code: _____

Authorization to Release Information and Assignment of Benefits

- By checking the box on the left, I certify that information I have reported about my insurance is correct.
- By checking the box on the left, I authorize the release of any medical information necessary to process my insurance claims.
- By checking the box on the left, I authorize my doctor to apply for benefits on my behalf for covered services rendered by him or her, or by his or her order. I request that payment be made directly to my doctor or to the party who accepts assignment.
- By checking the box on the left, I acknowledge that any insurance billing done is at the discretion of my doctor. I understand that any co-pays, co-insurances and deductions deemed my responsibility are payable in full by me.
- By checking the box on the left, I permit a copy of this authorization to be used in place of the original. This authorization may be revoked in writing by either me or my insurance company.

Signature of Patient/Parent/Legal Guardian _____ Date _____