Robert Fortino, D.O. Date:_____

PATIENT INFORMATION FORM

Patient Name: (Last)_____(First)_____(MI)_____

Name you prefer to be called: _____

Street Address: _____

City:_____ State:_____ Zip: _____

Home Phone:_____ Cell Phone:_____

Email: _____

Best Phone Number to Confirm Your Appointment:

_____

Please remember that we will never leave a message regarding weight loss, and only state that you have an appointment with Dr. Fortino.

Birthdate:_____Age:_____ Sex: M F

In Case of Emergency:

Name: _____ Relationship:_____ Phone:_____

Patient's Spouse: _____Phone:_____

Primary Care Physician: _____ Phone:_____

Referred by:_____

Financial Policy:

Thank you for selecting Robert Fortino, D.O. for your health care needs. We are honored to provide you this service. Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made. For your convenience, we accept Visa, MasterCard, debit cards and cash. We do not accept personal checks, American Express or Discover.

I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs.

I have read and understand all of the above and have agreed to these statements.

Patient's signature: _____ Date:_____