

Dr. Dathan Paterno

542 Busse Hwy.
Park Ridge, IL 60068

Patient Information:

Patient's Name: _____

Patient's Date of Birth: _____

Address: _____

City, Zip: _____

Home Phone: _____

Cell : _____

E-mail: _____

Other: _____

How would you like benefit information sent? Mail ___ E-mail: ___ Home Phone: ___

Where and to whom would you like billing information sent? _____

In order to save paper and postage, may we send monthly invoices to the e-mail you provided? YES ___ NO ___

If not, is there another e-mail address we may send invoices? _____

Insured Information (if different than patient):

Insured Name: _____

Insured's Date of Birth: _____

Address: _____

City, Zip: _____

Home Phone: _____

Cell : _____

E-mail: _____

Insured's Employer: _____

Insurance Company Information

Name Of Insurance Company and Plan: _____

Insured's ID Number (Include Alpha Prefix): _____ Insured's Policy #: _____

Credit Card: (Circle) Visa Mastercard AMEX

Card # _____ Expiration Date: _____ Security Code (3 or 4 digits): _____

Please sign to authorize the following charges on this account: _____

Office Use Only

Default Dx.: Adjustment D/O Other: _____ Testing? YES / NO

Yearly Deductible: \$ _____ Amount of deductible met so far: \$ _____

Co-pay for Outpatient Mental Health: \$ _____ Maximum visits per year: _____

Authorization required? Number to call for pre-authorization: _____