

PATIENT REGISTRATION

ID#	STEFANO FUSI, M.D. 5 DURHAM RD, GUILFORD, CT 06437 (203) 458-4444	Patient should complete white areas only.
LAST NAME	FIRST NAME & INIT	
ADDRESS		
CITY	STATE	ZIP
HOME PHONE	MARITAL STATUS (M/S/W/D)	
DATE OF BIRTH	SEX	
REFERRING M.D.	ADDRESS	PHONE
FAMILY M.D.	ADDRESS	PHONE
SPOUSE NAME	WORK PHONE #	
PAT. SOC SEC #		
PAT. EMPLOYER		
EMPLOYER ADDRESS		
CITY	STATE	ZIP
EMPLOYER PHONE	EXT	
RESponsible Party		
ADDRESS	RELATIONSHIP	DATE OF BIRTH
CITY	STATE	ZIP
RESponsible Party Employer		
EMPLOYER ADDRESS		
INSURANCE INFORMATION		
DOES YOUR INSURANCE COMPANY REQUIRE A REFERRAL? (Y/N)		
INSURANCE #1 NAME		
ADDRESS		
POLICY HOLDER NAME		
INSURANCE ID#	GROUP #	
INSURANCE #2 NAME		
ADDRESS		
POLICY HOLDER NAME		
INSURANCE ID #	GROUP #	
WORKERS COMP./ OTHER NAME		
ADDRESS		
DATE OF INJURY	INS PHONE #	
CLAIM #	CONTACT PERSON & PHONE#	
AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I authorize payment directly to the Physician for the surgical and/or medical benefits. I understand that I am responsible to pay for any non-covered services, co-pays, deductibles, and any remaining balances.		SIGNATURE (Patient or Parent if Minor) Date
AUTHORIZATION TO RELEASE INFORMATION: I authorize the Physician to release any information acquired in the course of my treatment to my insurance company or to my primary/referring physician in writing or by fax.		SIGNATURE (Patient or Parent if Minor) Date