

**MAURICIO E. MELHADO, M.D., P.A.**

3472 Forest Hill Blvd, Suite 3-B  
West Palm Beach, FL 33406

561-619-3051

**PATIENT INFORMATION: PLEASE PRINT AND ANSWER ALL QUESTIONS**

PATIENT'S NAME \_\_\_\_\_  
(LAST) (FIRST) (MIDDLE)

GUARANTOR (IF PATIENT IS CHILD) \_\_\_\_\_

FL. ADDRESS \_\_\_\_\_ APT# \_\_\_\_\_

CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_ PH# \_\_\_\_\_

SS# \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ SEX \_\_\_\_\_

SEASONAL ADDRESS \_\_\_\_\_ APT# \_\_\_\_\_

CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_ PH# \_\_\_\_\_

MARITAL STATUS \_\_\_\_\_ NATIVE LANGUAGE \_\_\_\_\_ DRIVER'S LICENSE# \_\_\_\_\_ STATE \_\_\_\_\_

EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_

ADDRESS \_\_\_\_\_ PH# \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ PH# \_\_\_\_\_

PHARMACY (PHONE NUMBER/ADDRESS) \_\_\_\_\_

**INSURANCE INFORMATION**

**PRIMARY**

NAME OF INSURANCE CO. \_\_\_\_\_ PH# \_\_\_\_\_

ADDRESS OF INSURANCE CO. \_\_\_\_\_

IF GROUP INSURANCE, PLEASE SPECIFY WHICH EMPLOYER CARRIES IT \_\_\_\_\_

NAME OF INSURED \_\_\_\_\_ POLICY# \_\_\_\_\_

GROUP# \_\_\_\_\_ MEDICARE# \_\_\_\_\_ AUTH# \_\_\_\_\_

**SECONDARY**

NAME OF INSURANCE CO. \_\_\_\_\_ PH# \_\_\_\_\_

ADDRESS OF INSURANCE CO. \_\_\_\_\_

IF GROUP INSURANCE, PLEASE SPECIFY WHICH EMPLOYER CARRIES IT \_\_\_\_\_

NAME OF INSURED \_\_\_\_\_ POLICY# \_\_\_\_\_

GROUP# \_\_\_\_\_ AUTH# \_\_\_\_\_

**ASSIGNMENT OF BENEFITS**

I authorize the release of any payment and medical information necessary to process this claim and related claims. I request payment of benefits to \_\_\_\_\_, M.D., P.A. who accepts assignment of benefits.

\_\_\_\_\_ DATE \_\_\_\_\_

**(Patient's or Authorized person's Signature)**

**REFERRING PHYSICIAN INFORMATION**

NAME \_\_\_\_\_ PH# \_\_\_\_\_  
(LAST) (FIRST) (MI)

**CONSENT FOR TREATMENT**

I voluntarily consent to the rendering of care, including treatment, administration of anesthetics and performance of diagnostic and/or surgical procedures. I understand that I am under the care and supervision of Mauricio E. Melhado, M.D., P.A and it is the responsibility of the staff to carry out instructions of such physician.

**ASSIGNMENT OF BENEFITS**

I hereby assign payment directly to Mauricio E. Melhado, M.D., P.A. accepting this assignment of medical benefits applicable and otherwise payable to me but not to exceed the physician's regular charges. **I understand that I am financially responsible for the charges not covered by this assignment or for any and all charges, which the insurance carrier declines to pay.** It is further agreed that any credit balance resulting from payment of insurance or other source may be applied to any other accounts owed to said physician(s) by the insured or his/her family.

**RELEASE OF INFORMATION**

The physician(s) may disclose all or part of the patient's record to any person or corporation which is or may be liable under a contract to the physician(s) or to the patient or to a family member or employer of the patient of physician(s) charges, including but limited to, insurance companies, worker's compensation carriers, welfare funds, or the patient' employer.

**MEDICARE AND THE MEDICAID PATIENT IDENTIFICATION-AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST**

I certify that the information given by me in applying for payment under Title XVIII and/or Title XIX, of the Social Security Act, is correct. I authorize any holder of medical or other information about me, to be released to the Social Security Administration or its intermediary carriers, any information needed for this or a related Medicare or Medicaid claim. I request payment for authorized benefits are made on my behalf. I assign the benefits payable for physician(s) services. **I understand that I am responsible for my health insurance deductibles and co-insurance.**

\_\_\_\_\_  
PRINT PATIENT'S NAME

\_\_\_\_\_  
DATE

\_\_\_\_\_  
WITNESS

\_\_\_\_\_  
PATIENT SIGNATURE OR REPRESENTATIVE

PATIENT UNABLE TO SIGN DUE TO: \_\_\_\_\_