CASTELLANO & HOWARD SPECIALTY CENTER

LISA M. CASTELLANO-HOWARD, M.D.
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813-879-6207
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PATIENT INFORMATION SHEET

(Please print clearly)

Married____ Widow____
Single____ Other____

Date:_____

Patient's Name:_____ Female □
(Last) (First) (Middle) Male □

What name do you want us to use when you are called in to see the doctor?_____

CIRCLE WHICH METHOD OF CONTACT YOU PERFER:

Date of Birth:_____ Daytime Phone:_____

Soc. Sec. No: _____ Evening Phone: _____

Email Address: _____

Address:_____
(Street) (City) (State) (Zip)

Referred By:_____ Insurance Co._____

Name of Insured_____Group #_____

Insured Soc. Sec. #_____ Insured Date of Birth _____

CONSULTATION REQUESTED BY:_____

* *

School/College:_____

Employer's Name:_____
(of spouse if you are unemployed)

Employer's Address:_____

Employer's Phone #_____

* *

Name of person you wish notified in case of emergency:

Name_____Relationship:_____

Address:_____Phone #:_____

Employer:_____

* *

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the undersigned Physician of the Surgical and/or Medical Benefits, if any otherwise payable to me.

AUTHORIZATION FOR INFORMATION: I hereby authorize the undersigned Physician to release/obtain any information acquired/needed in the course of my examination or treatment/or as requested by an insurance company.

Signed:X_____**Date:**_____

Primary Care Physician's/Practitioner's Name:_____