

MARTIN J. NAUGHTON, M.D.
PAMELA E. NETUSCHIL, M.D.
ELIZABETH A. HUTSON, M.D.

Referred by: _____

Patient Name: _____ Age: _____
(First) (Middle) (Last)

Date of Birth: _____ Are you: Single Married Separated Divorced Widowed

Mailing Address: _____ City: _____ State: _____ Zip: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Social Security #: _____

Patient Employer: _____ Position Occupied: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Work Phone: _____ ext. _____ Maiden Name: _____

Cell Phone: _____ E-mail: _____

Spouse/Parent: _____ Date of Birth: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Social Security #: _____

Spouse/Parent Employer: _____ Position Occupied: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Work Phone: _____ ext. _____

**Person to contact if patient cannot be reached: _____

Street Address: _____ Phone #: _____

Do you have any advanced directives (Living Will)? () Yes () No

*If yes, please allow our office to keep a copy in your medical records file.

In the event of a life-threatening emergency, is there moral, religious or other convictions that would prevent you from accepting a blood transfusion? () Yes () No

Primary Insurance Company: _____ Secondary: _____

Ins. Address: _____ City: _____ State: _____ Zip: _____

Name of Insured: _____ Group #: _____ ID #: _____

I hereby authorize Dr. Martin Naughton, Dr. Pamela Netuschil, or Dr. Elizabeth Hutson to furnish information to insurance carriers concerning my illness and treatment and I hereby assign the physician all payments for medical services rendered to myself or my dependents. I understand that I am financially responsible for the unpaid balance of my account in the event that my medical insurance does not pay the account in full. I further state that I have read the information sheet and understand and will comply with the policy set forth.

Normal PAP/lab results will be mailed to your home address.

We will call with abnormal results. 8:30 am - 4:30 pm M-F

- Cell # _____
- I give permission to leave a detailed message on my phone # _____
- Do not leave a message on my phone other than to call your office
- You have permission to leave information with _____

Patient Signature: _____ Date: _____

(signature required with or without insurance)

Important, please read carefully:

Most insurance carriers require that the insured use a contracted facility (hospital, laboratory, radiological facility, etc.). In order to obtain maximum reimbursement, you should contact your insurance company, to find which facilities are contracted, prior to receiving services. These contracted facilities change on a regular basis. **It is your responsibility to advise us of the contracted facility to be used.**