FRANK SCAFURI, III, D.O., P.C.

Internal Medicine and Infectious Diseases

Dr. Frank Scafuri, III *Derick Rias, RPA-C*
Dr. Madhvi Rana *Kristin Sweeney, RPA-C*
Dr. Azza Elemam *Jennifer Scafuri, NP-C*

PATIENT NAME:_____ **DATE OF BIRTH:**_____

ADDRESS: _____

CITY, STATE:_____ **ZIP CODE:**_____

TELEPHONE NUMBERS-HOME:_____**WORK:** _____**CELL:** _____

E-MAIL ADDRESS:_____

SOCIAL SECURITY NUMBER:_____

EMPLOYER:_____

OCCUPATION:_____

INSURANCE COMPANY:_____

NAME OF INSURED (IF DIFFERENT):_____

RELATIONSHIP TO INSURED:_____ **DATE OF BIRTH OF INSURED:**_____

SOCIAL SECURITY NUMBER OF INSURED:_____

REASON FOR TODAY'S VISIT:_____

_____

EMERGENCY CONTACT NAME AND TELEPHONE NUMBER:_____

_____

WHOM MAY WE THANK FOR YOUR REFERRAL?_____

INSURANCE AUTHORIZATION AND ASSIGNMENT:

682 Forest Avenue
Staten Island, New York 10310
(718) 370-3730 (*phone*)
(718) 698-9412 (*facsimile*)

Website: www.drscafuri.com
Email: drfrankscafuri@gmail.com

I hereby authorize the above referenced practitioners to furnish information to insurance carriers concerning my illness and treatment and I assign to the practitioners all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

SIGNATURE:_____**DATE:**_____

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