NO PERFUME OR COLOGNE ALLOWED IN OFFICE. THANK YOU

ALLERGY, SINUS & ASTHMA SPECIALISTS of NAPLES

Brett E. Stanaland, M.D., P.A.
Maria T. Olivero, M.D.
1000 Goodlette Road North, Suite 200
Naples, Florida 34102 (239) 434-6200

REGISTRATION

(Please Print) E-mail Address_____

Date: _____ Home Phone: _____

Cell Phone:_____

Patient: _____

Last Name First Name Middle

Responsible Party Name (if a minor): _____

Local Street Address: _____

City: _____State: _____Zip: _____

Secondary Street Address: _____Phone: _____

City: _____State: _____Zip: _____

Sex ☐ M ☐ F **AGE: ____yrs Birth date: ___/___/____** ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Who is responsible for this account?_____Relation to patient:_____

Patient/Primary Insurance Holders Employed By:_____

Business Address: _____

Occupation:_____Business Phone:_____

Patient's Social Security #_____-____-_____ Policy Holder Social Sec #_____-____-_____

Do you have Medical Insurance? ☐ No ☐ Yes➔ If yes; Policy Holders Birthdate: ____/_____/_____

Name of Primary Insurance: _____

Name of Secondary Insurance (If Any): _____

☐ Medicare ☐ Medicaid

Primary Physician: _____

Did a physician refer you? ☐ Yes ☐ No. If yes by whom: _____

In case of emergency, who should be notified?_____Phone No:_____

How did you learn of our practice? _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____
Name of Insurance Company
and assign directly to Dr. Brett E. Stanaland all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions

_____ _____
Signature of Insured/Guardian Date

MEDICARE AUTHORIZATION
I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Brett E. Stanaland for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____
Beneficiary Signature Date