

GUSTAVO H. DAY, M.D.,P.A.

PATIENT INFORMATION				
Last Name:		First Name:		M.I.:
Date of Birth:	Sex: M F	Marital Status: M S D W		
Social Security #:		Driver License#:		
Street Address:				
City:		State	Zip Code	
Home Phone #		Work Phone #		
Employer Name:				
Employer address:				
City:		State:	Zip Code:	
Person to contact in case of Emergency:				Phone:
RESPONSIBLE PARTY				
Parent/ Insured's Name				Phone#:
Parent/ Insured's Address:				
Date of Birth:	Sex: M F	Social Security#		
Guarantor's Relationship to Patient:				
Parent/ Insured's Employer:				
Parent/ Insured's Employer Address:				
Home Phone #		Work Phone#:		
Is the Patient a Full Time Student:		Yes	No	
PRIMARY INSURANCE INFORMATION				
Insurance Name:				ID/SS#:
Insured's Name:				Group#:
Ins. Co Address:				
City:		State:	Zip Code	Ins.Phone#:
SECONDARY INSURANCE INFORMATION				
Insurance Name:				ID/SS#:
Insured's Name:				Group#:
Ins. Co. Address:				
City:		State:	Zip Code:	Ins.Phone#:

Financial Policy

We must have a copy of all insurance cards, driver's license or ID at the time of service
HMO and PPO and Medicare patients must pay deductibles and co-pays.
Co-pays and Deductibles payments are expected at the time of service.
Private pay Patients must pay in full at the time of service.
Patient must show insurance card at each office visit and notify of any change of address

Patient Signature

Date