

STEPHEN M. EVANGELISTI, M.D.

1901 Lac De Ville, Suite 2
Rochester, New York 14618
585-325-1120

Date: _____

Name: _____ DOB: _____ Age: _____

Address: _____ Home Phone: _____

_____ Work Phone: _____

City _____ Zip Code _____ Cell Phone: _____

Social Security #: _____ Email Address: _____

Pharmacy Name: _____ Pharmacy Phone: _____

Pharmacy Address: _____

Primary Care Physician: _____ Employer: _____

Address: _____

Phone: _____ Referred By: _____

Primary Insurance: _____ Secondary Insurance: _____

Subscriber's ID #: _____ Subscriber's ID #: _____

Subscriber's Name: _____ Subscriber's Name: _____

Subscriber's DOB: _____ Subscriber's DOB: _____

If this is a Workers' Compensation Injury or Motor Vehicle Accident, please complete this section.

Workers' Compensation Injury

Date of Injury: _____ Employer at time of injury: _____

Case #: _____ Case Manager: _____

Carrier: _____ Carrier Address: _____

Motor Vehicle Accident

Responsible Insurance Company: _____ Address: _____

Policy Holder: _____ Policy Number: _____

Policies

- I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance; including cost of collections and attorney fees. I also authorize Stephen M. Evangelisti, M.D. or insurance company to release any information required for processing of medical claims.
- If cosmetic surgery is scheduled at a surgery center; a 30 day notice prior to the surgery date is needed. Otherwise, a cancellation fee of \$500.00 will be incurred by the patient. If patient cancels seven (7) days or less prior to the scheduled surgery date, 50% of the total surgeon fee will be non-refundable.
- A \$25.00 returned check fee will be applied to your account for any checks returned for non-payment.
- We request 48-hours notice for appointment cancellations. A cancellation fee of \$50.00 will be applied to your account if this notice is not received.
- A chaperone will be present in all medical exams, unless declined by patient.
Signature, if declined: _____

• I would like to receive text message appointment reminders ___ Yes ___ No

• I would like to receive e-mail appointment reminders ___ Yes ___ No

Signature: _____ Date: _____