Peter J. Sakol, M.D., L.L.C.

PATIENT INFORMATION – Please Print

Patient's Last Name	First	M.I.

Age	Date of Birth	□ M □ F	Street Address	Apt. #

City	State	Zip Code	Social Security #

Home Phone	Work Phone	Cell Phone	Marital Status

Patient's Occupation	Employer's Name	Address

Person to Notify (Name & Address)	Phone #

Referred By	Address

Family Physician	Address

FINANCIAL RESPONSIBILITY

Relationship to Patient	Last Name	First	M.I.	SS #	Date of Birth

Street Address	City	State	Zip Code

Home Phone	Work Phone	Employer's Name and Address

INSURANCE – Please present your insurance card to the receptionist

Insurance Company Name & Address		

Identification #	Group	Effective Date

Policy Holders Name and Address	Date of Birth

SECONDARY INSURANCE – Please present your insurance card to the receptionist

Insurance Company Name & Address		

Identification #	Group	Effective Date

Policy Holders Name and Address	Date of Birth

I consent to treatment necessary for the care of the above named patient.
I authorize the release of all medical records to the referring and/or family physician and insurance company, if applicable.
I allow fax transmittal of my medical records, if necessary.
I acknowledge full financial responsibility for services rendered by Peter J. Sakol, M.D., LLC.
I agree to pay all reasonable attorney fees and collection cost in the event of default of payment of my charges.
I authorize and request that insurance payments be made directly to Peter J. Sakol, M.D., LLC.
I understand that payment of charges occurred is due at the time of service unless other definite financial arrangements have been made prior to treatment.
I have read and fully understand the above and sign with the intent to be legally bound.

_____ _____

Date Signature of Patient or Responsible Party

2025 Technology Parkway ● Suite 205 ● Mechanicsburg, Pennsylvania 17050 ● (717) 791-2920 ● fax (717) 791-2921