ALLERGY ♦ SINUS
ASTHMA

Roger N. Danziger M.D.
Board Certified
Allergy / Asthma / Immunology

Patient's Legal Name______________________________ Parent/Guardian_________________

Street Address_____________________________ City/State______________ Zip_________

Cell Phone_____________________ Home Phone_________________ Sex Male / Female

SS#_______________ Birth date____________ Email Address________________________

Patient's Employer______________________ Patient's Occupation_______________________

Primary Physician ______________________ **Referring Doctor** _______________________

In Case of Emergency Notify______________________ Phone______________ Relation_________

Guarantor/ Policy Holder Information

Insured Name_________________________________ SS#________________________

Address _______________________________ City/ State________________ Zip_______

Birth date ____________ Home____________________ Cell ______________________

Employer ___________________________ Business Phone_________________________

Relation to Patient ________________________ Email Address__________________________

I authorize the release of any medical information necessary to process insurance claims. I further authorize payments of medical benefits to Roger N. Danziger, M.D., P.A. in the event they file for insurance.

____ **Date**________________________
Patient(s) or Guardian Signature

If you are covered by Medicare, please complete the following:

LIFETIME MEDICARE B SIGNATURE AUTHORIZATION: For Service beginning _______________________
I authorize any holder of other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, or the billing agents of Roger N. Danziger, M.D. P.A. any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used on place of the original and request payment of medical insurance benefits either to my-self of the party who accepts assignment.

Patient's Signature____

By ____ (if other than the beneficiary)

Reason patient is unable to sign____

5404 Cortez Road West
Bradenton, Florida 34210
Office@NozDoc.com

Phone: (941) 761-1911
Fax: (941) 761-9223
www.NozDoc.Com