



**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 _____ Alternative Phone _____ Sex Male / Female

SS# _____ Birthdate _____ 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 _____

Birthdate _____ 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.

Patient's or Guardian Signature Date _____

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 myself of the party who accepts assignment.

Patient's Signature _____

By _____ (if other than the beneficiary)

Reason patient is unable to sign _____

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