Oakview Medical Group
Sonja Fontana DNP, FNP
Patient Information Form

Please Print

Name: _____ Hm Phone: _____ Wk Phone: _____
Address: _____ City: _____ State: ____ Zip: _____
Sex: M/F Birth Date: _____ SSN: _____-_____- _____
E-Mail Address: _____ Cell Phone: _____
Employer: _____ Address: _____
Spouse/Parent: _____ SSN: _____-_____-_____
Emergency Contact: _____ Phone Number: _____
Who may we thank for referring you? _____

Insurance Information

Primary Insurance: _____ Effective Date: _____
Cardholder Name: _____ DOB: _____ Relationship to pt: _____
ID #: _____ Group #: _____ Plan #: _____

Secondary Insurance: _____ Effective Date: _____
Cardholder Name: _____ DOB: _____ Relationship to pt: _____
ID #: _____ Group #: _____ Plan #: _____

Allergies: Please List _____

I authorize any holder of any medical information about me/my family to release information to third party payers in order to determine benefits for services provided. I authorize payment by my third party payers to Sonja Fontana, DNP, FNP. I permit a copy of this authorization to be used as the original. I have verified that the office of Sonja Fontana, DNP, FNP is the facility I/my family may use for the insurance contract under which I/my family is covered. **I understand that if the previous is not true I am responsible for payment of charges related to services, supplies, products or equipment provided to me or my family.**
I authorize that Sonja Fontana, DNP, FNP and staff to render medical treatment to me/my family. Except for medical emergencies, any patient/guardian who refuses to complete and sign this authorization for treatment may be denied services. I have read and agreed to the above conditions.

_____ _____ _____ _____
Signature Date Signature Date

_____ _____ _____ _____
Signature Date Signature Date