

**Peter M. Schissler, M.D. Stuart J. Turkewitz, M.D. Stephanie Trifoglio, M.D.**  
7500 Greenway Center Drive Suite 430  
Greenbelt, MD 20770

**PATIENT INFORMATION**

Patient Name: (last) \_\_\_\_\_ (first) \_\_\_\_\_ (m.i.) \_\_\_\_\_

Patient's Address: (street) \_\_\_\_\_

(City, state, zip code) \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_ Sex: M/F Social Security Number: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**EMPLOYMENT INFORMATION**

Name of Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

**CONTACT INFORMATION**

Emergency Contact Name: \_\_\_\_\_ Phone \_\_\_\_\_

Person to be called with test results: \_\_\_\_\_ Phone \_\_\_\_\_

If you are unavailable, may we give them to anyone else? Yes /No

If yes, to whom can we give them: \_\_\_\_\_ Telephone: \_\_\_\_\_

**INSURANCE INFORMATION**

Name of Insured (if other than patient): \_\_\_\_\_

Insured Social Security Number: \_\_\_\_\_ Insured's Date of Birth: \_\_\_\_\_

Medicare Number: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Address: \_\_\_\_\_

Group Number: \_\_\_\_\_ Policy Number: \_\_\_\_\_

**AUTHORIZATION AND ASSIGNMENT**

I hereby authorize Drs. Schissler, Turkewitz, Trifoglio and/or their associates to apply for benefits on my behalf for covered services to me. I request payment from my insurance company be made directly to the provider of services. I certify that the information I have reported with regard to my insurance is correct. I authorize the release of medical or other necessary information for this or any related claim to my insurance carrier, Social Security, or Health Care Financing Administration (for Medicare). I permit a copy of this authorization to be used in place of the original. I have read and consent to the above authorization and assignment as stated.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_