DR JOHN P SALERNO

SALERNO WELLNESS

PATIENT REGISTRATION

PREFERRED OFFICE LOCATION

☐ NY ☐ CT

EMAIL ADDRESS

DATE

FULL NAME

DOB

AGE

SEX ☐ MALE ☐ FEMALE

ADDRESS

MOBILE PHONE

HOME PHONE

PCP

HOW DID YOU HEAR ABOUT THE SALERNO WELLNESS CENTER?

WHO DO WE THANK FOR REFERRING YOU?

EMERGENCY CONTACT NAME

RELATIONSHIP

EMERGENCY CONTACT NUMBER

PHARMACY INFORMATION

PHARMACY NAME

PHARMACY ADDRESS

INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER

ID NUMBER

GROUP NUMBER

PRIMARY INSURED

EMPLOYER NAME

EMPLOYEE DATE OF BIRTH

EMPLOYEE SOCIAL SECURITY NUMBER

FINANCIAL RESPONSIBILITY

PERSON RESPONSIBLE FOR ACCOUNT ☐ SELF ☐ SPOUSE ☐ PARENT

NAME

SOCIAL SECURITY NUMBER

ADDRESS

TELEPHONE

EMAIL ADDRESS

CREDIT CARD PAYMENT AUTHORIZATION

I, _____, hereby authorize the Salerno Wellness Center for Complementary Medicine to charge my credit card for services rendered and/or products supplied for a period of one year from the date below. It is my responsibility to notify of any changes regarding this credit card authorization.

NAME ON CARD

SIGNATURE

CREDIT CARD NUMBER

EXPIRATION DATE

SECURITY CODE

BILLING ZIP CODE

CARD TYPE ☐ MASTERCARD ☐ VISA ☐ AMERICAN EXPRESS ☐ DISCOVER

I attest, to the best of my knowledge, the above information is accurate and true.

SIGNATURE

DATE

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