Full Name: Last First MI

Address:

City State Zip

Home Phone: Cell Phone:

Fax #: Email Address:

Date of birth: Sex: Marital Status:

Emergency Contact Name Emergency Phone:

Referred by: Physician Other

Patient SS#:

Employer: Work Phone:

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**AUTHORIZATION TO PAY PHYSICIAN:** I hereby authorize payment directly to Benjamin Mena, M.D., P.A. for all services rendered by the physician of the services described.

**AUTHORIZATION TO RELEASE MEDICAL RECORDS:** I hereby authorize release of medical records to insurance company if needed for payment of services rendered by physician.

**SIGNATURE:(PATIENT OR PARENT IF MINOR: X**

**DATE:**