PATIENT INFORMATION

Please print

DATE ________________

Who is responsible for Patient: self ❐ parent ❐ employer ❐ other ❐ ________________

Patient's Last Name ________________ First ________________ Middle Initial ________

Patient's Social Security Number ________________

Address: ________________ Apt. #: ________

City: ________________ State: ________________ Zip Code: ________

Telephone #: Home (____) ________________ Business (____) ________________

Date of Birth: ________________ Sex: ❐ Male ❐ Female

Do you have an alternate address? ❐ Yes ❐ No If yes, please print here: ________________

Marital Status (check one): ❐ Single ❐ Married ❐ Divorced ❐ Widowed ❐ Separated

Employment Status (check one): Full-Time ❐ Part-Time ❐ Retired ❐ Other ________________

Employer: ________________ Occupation: ________________

Employer Address: ________________

Student: Full-Time ❐ Part-Time ❐

Spouse/Parent Name: Last ________________ First ________________ Middle Initial ________

SSN: ________________ Birthdate: ________________

Employed By: ________________

Address: ________________ Phone #: ________________

Spouse/Parent Name: Last ________________ First ________________ Middle Initial ________

SSN: ________________ Birthdate: ________________

Employed By: ________________

Address: ________________ Phone #: ________________

Name of closest relative not living with you: ________________

Relationship: ________________ Phone #: ________________

Referring Physician: ________________

Address: ________________ Phone #: ________________

PLEASE HAVE YOUR INSURANCE CARD AND DRIVER'S LICENSE READY FOR THE RECEPTIONIST.
PAYMENT FOR PROFESSIONAL SERVICES IS DUE AND PAYABLE WHEN SERVICE IS RENDERED.

Please Fill Out Reverse Side.

D43300 (2/05)

NO SHOW POLICY

If you are unable to keep your appointment, please show consideration and give the office 24 hours notice prior to your appointment to avoid a possible fee of $25.00.

PATIENT SIGNATURE ______________________ DATE ______________

MEDICAID POLICY

Our office does not accept Medicaid as a secondary insurance. Therfore, you will be responsible for any remaining balance that your primary insurance does not cover.

PATIENT SIGNATURE ______________________ DATE ______________

INSURANCE ASSIGNMENT

I hereby authorize my insurance benefits to be paid directly to Florida Physicians Medical Group. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered.

PATIENT SIGNATURE ______________________ DATE ______________

FOR MEDICARE PATIENTS ONLY

MEDICARE PART B SIGNATURE AUTHORIZATION - LIFETIME

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare Claim. I permit a copy of this authorization to be used in place of the original. I request that payment of the authorized benefits be made of my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to medicare for payment to me.

PATIENT NAME ______________________ PATIENT SIGNATURE ______________________

MEDICARE B # ______________________ DATE ______________________

RELEASE OF MEDICAL RECORDS

I hereby authorize the release of medical, psychiatric, alcohol, HIV testing and/or drug abuse information for insurance carriers or for continuing patient care.

Any of the classifications above may be crossed off if that information is not to be released.

SIGNATURE OF PATIENT ______________________ DATE ______________

SIGNATURE OF PARENT,GUARDIAN, AND/OR RESPONSIBLE PARTY ______________________ DATE ______________

CONSENT FOR EVALUATION OR TREATMENT

The undersigned hereby consents to whatever evaluation or treatment the assigned physician may deem necessary to the patient named above.

PATIENT, PARENT, LEGAL GUARDIAN OR AUTHORIZED REPRESENTATIVE ______________________ DATE ______________