PATIENT INFORMATION

Please Print Clearly

Today's Date______________

PATIENT NAME: ____ DOB__/__/__ AGE__________ SEX ____________
mo day yr

ADDRESS: ____ CITY ____________________ STATE________ ZIP__________

HOME # (______) ________________________ SOCIAL SEC. # ______/____/______ DRIVERS LIC #____________________

CELL # (______) ________________________ MARITAL STATUS: MARRIED ________SINGLE ________ OTHER__________

OCCUPATION/EMPLOYER: ____

WORK # (______) ________________________EXT__________

SPOUSE'S NAME or
PARENT/GUARDIAN NAME: ____ PHONE: ________________

LIST PERSON WHO DOES NOT LIVE WITH YOU TO CONTACT IN AN EMERGENCY:

NAME: ____ PHONE: ________________

PRIMARY CARE PHYSICIAN/REFERRING DOCTOR: ____

PRIMARY INSURANCE COMPANY: ____

COMPANY ADDRESS: ____
STREET CITY STATE ZIP

SUBSCRIBER (POLICY HOLDER) ________________________________ POLICY HOLDER BIRTHDATE__________

POLICY NUMBER ________________________GROUP NUMBER________________________________

POLICY TYPE: ☐ INDIVIDUAL ☐ GROUP ☐ SUPPLEMENTAL ☐ OTHER ________________________

POLICY TYPE: PATIENT RELATIONSHIP TO SUBSCRIBER (POLICY HOLDER) ____________________

SECONDARY INSURANCE COMPANY: ____

COMPANY ADDRESS: ____
STREET CITY STATE ZIP

SUBSCRIBER (POLICY HOLDER) ________________________________ POLICY HOLDER BIRTHDATE__________

POLICY NUMBER ________________________GROUP NUMBER________________________________

POLICY TYPE: ☐ INDIVIDUAL ☐ GROUP ☐ SUPPLEMENTAL ☐ OTHER ________________________

POLICY TYPE: PATIENT RELATIONSHIP TO SUBSCRIBER (POLICY HOLDER) ____________________

Please Note: All necessary lab work, blood test, and pathology will be billed separately by an outside lab. (Please notify nurse if special lab is required.)

PATIENT SIGNATURE: ____

PHARMACY OR DRUG STORE: NAME:____________________________________

PHONE:____________________________________

over→

LIFETIME AUTHORIZATION
INSURANCE ASSIGNMENTS AND AUTHORIZATION TO RELEASE INFORMATION

I. RELEASE OF INFORMATION - I, the below named patient, do hereby authorize any physician examining and/or treating me to release any third payor (such as insurance company or governmental agency, example: Blue Shield of Florida or Medicare) any medical, psychiatric condition, alcohol or drug related condition and recommending diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for such treatment and/or diagnosis.

II. PHYSICIANS INSURANCE ASSIGNMENT - I, the below named subscriber, hereby authorize payment directly to any physician examining or treating me of any group and/or individual surgical and/or medical benefits herein specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charge for these services.

III. MEDICARE/MEDICAID - Patient's certification authorization to release information and payment request. I certify that the information given by me in applying for payment under Title XVII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration Division of Family Services or its intermediaries or carriers any information needed for this or a related Medicare/ Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.

IV. I PERMIT A COPY OF THESE ASSIGNMENTS AND AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE PHYSICIAN'S OFFICE. This assignment will remain in effect until revoked by me in writing.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and other pay a percentage of the charges. I understand it's my responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by my insurance or third party payor within a reasonable period of time not to exceed 60 days.

If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and charges for collection.

Date: ______________________ Patient: ______________________

Signature