



Dept. \_\_\_\_\_

**PATIENT INFORMATION**

**DATE** \_\_\_\_\_ **E-MAIL ADDRESS** \_\_\_\_\_

**PATIENT NAME** 1st MIDDLE LAST \_\_\_\_\_ **AGE** \_\_\_\_\_ **DATE OF BIRTH** \_\_\_\_\_

**SS#** \_\_\_\_\_ **DRIVER LIC. NO./STATE** \_\_\_\_\_  MARRIED  WIDOWED  MALE  
 SINGLE  DIVORCED  FEMALE

**LOCAL ADDRESS** APT# CITY STATE ZIP \_\_\_\_\_ **PHONE** [ ] [ ]

**PERMANENT ADDRESS** \_\_\_\_\_ **PHONE** [ ] [ ]

**PERSON TO PAY BILL** \_\_\_\_\_ **RELATIONSHIP** \_\_\_\_\_

**ADDRESS** \_\_\_\_\_ **PHONE** [ ] [ ]

\_\_\_\_\_ **CELL PHONE** [ ] [ ]

**NAME OF SPOUSE (OR PARENT)** \_\_\_\_\_

**PATIENT EMPLOYERS** \_\_\_\_\_ **OCCUPATION** \_\_\_\_\_ **WORK PHONE** [ ] [ ]

**ADDRESS** \_\_\_\_\_

**SPOUSE/PARENT EMPLOYER** \_\_\_\_\_ **WORK PHONE** [ ] [ ]

**ADDRESS** \_\_\_\_\_

**TO NOTIFY IN CASE OF EMERGENCY** \_\_\_\_\_ **RELATIONSHIP** \_\_\_\_\_ **PHONE** [ ] [ ]

**REFERRED BY** \_\_\_\_\_

**INSURANCE INFORMATION**

**PRIMARY INSURANCE**

**INS. CO.** \_\_\_\_\_

**ADDRESS** \_\_\_\_\_

\_\_\_\_\_ **PHONE** \_\_\_\_\_

**POLICY #** \_\_\_\_\_

**GROUP #** \_\_\_\_\_

**INSURED NAME** \_\_\_\_\_ **DOB** \_\_\_\_\_ **SEX**  M  F

**SECONDARY INSURANCE**

**INS. CO.** \_\_\_\_\_

**ADDRESS** \_\_\_\_\_

\_\_\_\_\_ **PHONE** \_\_\_\_\_

**POLICY #** \_\_\_\_\_

**GROUP #** \_\_\_\_\_

**INSURED NAME** \_\_\_\_\_ **DOB** \_\_\_\_\_ **SEX**  M  F

**AUTHORIZATION TO PAY / FOR MEDICARE, LIFETIME AUTHORIZATION**

I authorize any holder of medical or other information about me to release to my insurance company, and, for Medicare/Blue Cross/Blue Shield to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers or to the billing agent of Blue Cross/Blue Shield of Florida, any information needed for this or a related insurance or claim. I permit a copy of this authorization to be used in place of the original. I further authorize payment of medical and/or surgical insurance benefits, otherwise payable to me, to the party who accepts assignment. I understand that I am financially responsible for those charges not paid by my insurance.

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

OTHER SIGNATURE/REASON, IF PATIENT IS UNABLE TO SIGN \_\_\_\_\_ DATE \_\_\_\_\_