

# FLORIDA PHYSICIANS MEDICAL GROUP

## PATIENT INFORMATION

Please Print

DATE \_\_\_\_\_

Patient's Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_

Patient's Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex  Male  Female

Address \_\_\_\_\_ Apt. # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone # Home \_\_\_\_\_ Cell \_\_\_\_\_

Work \_\_\_\_\_ E:mail: \_\_\_\_\_

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  School Name and address: \_\_\_\_\_

Spouses/Parent Name: Last \_\_\_\_\_ First: \_\_\_\_\_ Middle Initial \_\_\_\_\_

SSN \_\_\_\_\_ Birth date \_\_\_\_\_ Age \_\_\_\_\_

Employed By \_\_\_\_\_

Address \_\_\_\_\_ Phone # \_\_\_\_\_

Insured: Last \_\_\_\_\_ First: \_\_\_\_\_ Middle Initial \_\_\_\_\_

SSN \_\_\_\_\_ Birth date \_\_\_\_\_ Age \_\_\_\_\_

Employed By \_\_\_\_\_

Address \_\_\_\_\_ Phone # \_\_\_\_\_

Name of closest relative not living with you \_\_\_\_\_

Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

How were you referred to this office?: Friend Family Advertisement Other \_\_\_\_\_

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.**

## CONSENT FOR EVALUATION OR TREATMENT

The undersigned hereby consents to whatever evaluation or treatment the assigned healthcare provider may deem necessary to the patient name above.

\_\_\_\_\_  
PATIENT, PARENT, LEGAL GUARDIAN OR AUTHORIZED REPRESENTATIVE

\_\_\_\_\_  
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 on 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

## ADVANCE DIRECTIVE

I understand that the terms of any Advance Directive that I have executed will be followed by the health care facility and my care givers to the extent permitted by law. Please check one of the following statements:

- I HAVE executed an Advance Directive.  
(Living Will, Durable Power of Attorney, Designation of a Health Care Surrogate.)

Please provide copies of Advance Directive/Living Will to the receptionist to be included in your medical record.

- I HAVE NOT executed an Advance Directive.  
(Living Will, Durable Power of Attorney, Designation of a Health Care Surrogate.)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_