Patient Information

2020

Please print

Patient Name_____ Today's Date_____
Last First MI

Date of Birth_____/_____/_____ Age*_____ O Male O Female Marital status: O S O M O D O W
Month Day 4-digit Year

Permanent Address_____ Apt#_____ _____ _____ _____
Street City State ZIP

Temporary Address_____Apt#_____ _____ _____ _____
(if applicable) Street City State ZIP

Mailing Address (If different from permanent address) _____

Social Security Number_____ Home telephone (_____)_____

Place of Employment:_____ Cell phone (_____)_____

What number would you prefer us to use to contact you? O Home O Cell O Work

Work phone (_____)_____Ext_____

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Living Will / Advance Directives

I have A Living Will / Advance Directives O Yes O No I would like more information O Yes O No

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Emergency Contact Information / Permission to Release Information

I authorize ***Our Family Doctors*** to discuss my healthcare (including test results) with the emergency contact person listed below:

Name_____Relationship_____ Phone #(_____)_____

In addition, to the above listed person, I authorize *Our Family Doctors* to release information regarding my health care to the additional person(s) listed below:

Name_____ Relationship_____ Phone #(_____)_____

Name_____ Relationship_____ Phone #(_____)_____

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Insurance / Payment Information

***** ** ** *Please present your insurance card to the Receptionist* ** ** **

Primary Health Ins Company: _____
Policy Holder's Name_____ Policy Holder's Date of Birth_____
Policy Holder's relationship to Patient_____ Policy Holder's Employer_____

Secondary Health Ins Company: _____
Policy Holder's Name_____ Policy Holder's Date of Birth_____

Person Financially Responsible for this account _____Relationship to pt: _____

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Treatment of Minors

Signature* of O Parent O Guardian_____ Print Name _____

*Florida law requires consent from a parent or legal guardian prior to a minor being treated in our office. (FS 743.0645)

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I grant permission to the staff of *Our Family Doctors* to obtain medical information regarding my health and treatment from any physician, hospital, skilled facility, ALF, or outpatient facility.

I authorize payment of medical benefits from my insurance carrier to be made to *Our Family Doctors*. I understand that I am ultimately responsible for all charges related to my care whether or not it is covered by my insurance. I agree to pay co-payments, coinsurance, and/or deductibles at the time service is rendered.

Signature:_____ Date_____