# 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 SEVICE IS RENDERED.**

Cfs rev. 3/01/07

**PLEASE FILL OUT REVERSE SIDE.**

## 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:____________