



FLORIDA HOSPITAL MEDICAL GROUP

PATIENT INFORMATION

Please Print

DATE _____

Patient's Last Name _____ First Name _____ Middle Name _____
 Suffix _____ Gender: Male Female Social Security Number _____ Date of Birth _____
 Race _____ Ethnic Group: Hispanic Non-Hispanic Unknown Preferred Language _____ Marital Status _____

Mailing Address _____ Country _____ Zip Code _____ City _____ State _____ County _____
 Home Address _____ Country _____ Zip Code _____ City _____ State _____ County _____
 Home Ph.(____) _____ Cell Ph. (____) _____ Work Ph. (____) _____ Ext _____ Email Address _____
 Primary Care Physician _____ Referring Physician _____
 Employment Status Full-Time Part-Time Retired Retired Date _____
 Employer _____ Occupation _____

WHO IS FINANCIALLY RESPONSIBLE FOR THE PATIENT (GUARANTOR)
 Self _____ Spouse _____ Parent _____ Other _____ Gender _____
 Last Name _____ First Name _____ Middle Name _____
 SSN _____ Date of Birth _____ Home Ph.(____) _____ Cell Ph. (____) _____ Work Ph. (____) _____
 Street Address _____ Country _____ Zip Code _____ City _____ State _____
 Employment Status Full-Time Part-Time Retired Retired Date _____
 Employer Name _____

Policy Holder Information (if Different from Patient). If same as responsible, please check here
 Self _____ Spouse _____ Parent _____ Other _____ Gender _____
 Last Name _____ First Name _____ Middle Name _____
 SSN _____ Date of Birth _____ Home Ph.(____) _____ Cell Ph. (____) _____ Work Ph. (____) _____
 Street Address _____ Country _____ Zip Code _____ City _____ State _____
 Employment Status Full-Time Part-Time Retired Retired Date _____
 Employer Name _____

Emergency Contact (Parent / Guardian if patient is a minor)
 Name _____ Relationship _____
 Home Ph.(____) _____ Cell Ph. (____) _____ Work Ph. (____) _____

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.

PLEASE FILL OUT REVERSE SIDE.

CONSENT FOR EVALUATION OR TREATMENT

The undersigned hereby consents to 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 Hospital 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