

PATIENT INFORMATION

PATIENT Name _____
(Last) (First) (Middle)
Date of Birth _____ Age _____ Sex: M F Soc. Sec. # _____
Address _____
(Street) (City) (State) (Zip)
Telephone No. _____ Marital Status _____
Employer Name Or Student _____ Telephone No. _____

RESPONSIBLE PARTY Name _____
(Last) (First) (Middle)
Telephone No. _____ Date of Birth _____ Soc. Sec. # _____

PRIMARY INSURANCE Name _____ Telephone No. _____
Insured's Name _____ Soc. Sec. # _____
(Last) (First) (Middle)
Date of Birth _____ Relationship to Insured: Self Spouse Child Other

SECONDARY INSURANCE Name _____ Telephone No. _____
Insured's Name _____ Soc. Sec. # _____
(Last) (First) (Middle)
Date of Birth _____ Relationship to Insured: Self Spouse Child Other

EMERGENCY Next of kin _____
(Last) (First) (Middle)
Telephone No. _____ Relationship to Patient _____

We require full payment at the time of service. A twenty-five dollar (\$25) charge will be assessed to all insufficient funds and checks. How do you plan to pay for this visit? CASH _____ CHECK _____ CREDIT CARD _____

I hereby give consent to **Orlando Primary Care, PA** to provide whatever treatment the assigned physicians may deem necessary to the patient named above. I understand that I am responsible for payment to **Orlando Primary Care, PA** for any medical or hospital charges, and that payment is due at the time of service. In the event of insurance coverage, I understand that **Orlando Primary Care, PA** will file my claim and I am responsible for charges not covered by the insurance policy. If my insurance company has not responded within 120 days, I understand that I will be responsible for the full payment.

I hereby request payment of authorized Medicare benefits and/or any insurance benefits to be made whether to me or on my behalf to **Orlando Primary Care, PA** for any services furnished to me by the physician. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature of Patient _____ Date _____