PATIENT INFORMATION

First Middle Last

E-Mail Address

Address

( ) - Phone Number

/ / Date of Birth

City State Zip Code

Patient Social Security Number ☐☐☐ - ☐☐ - ☐☐☐☐

Please Present Driver's License for Photo Copy

Method of Payment: ☐Cash ☐Check ☐BkCard ☐Ins ☐Other **Marital Status:** ☐M ☐S ☐W ☐D **Sex:** ☐M ☐F

Fees are payable at the time examinations, x-rays, and treatments are received, unless other arrangements are made in advance.
FLORIDA LAW REQUIRES THAT PATIENT RECORDS, INCLUDING X-RAYS, BE RETAINED BY THE PHYSICIAN

Primary Insurance Information

Insurance Company

Name of Insured (If Other Than "Self")

Patient Relationship to Insured:

☐ Self ☐ Spouse ☐ Child ☐ Other

Address

City State Zip Code

( ) - Phone Number

Policy / Claim #

Please Present Insurance Card for Photo Copy

FOR OFFICE USE ONLY

Type of Insurance:

AUTO WC MM HMO PPO MED MDC OTHER:

Coverage: CoPay:

Limitations:

Contact:

Secondary Insurance Information

Insurance Company

Name of Insured (If Other Than "Self")

Patient Relationship to Insured:

☐ Self ☐ Spouse ☐ Child ☐ Other

Address

City State Zip Code

( ) - Phone Number

Policy / Claim #

Please Present Insurance Card for Photo Copy

FOR OFFICE USE ONLY

Type of Insurance:

AUTO WC MM PPO MED/SUPL MDC OTHER:

Coverage: CoPay:

Limitations:

Contact :

IS YOUR CURRENT CONDITION THE RESULT OF AN ACCIDENT? ☐ YES ☐ NO

IF YOU HAVE AN ATTORNEY, PROVIDE INFORMATION REQUESTED BELOW. **DATE OF ACCIDENT**: / /

Attorney Name: Phone:

Address: City, State, Zip:

Employment Information:

Employer:

Address:

City, State, Zip:

Phone: ( ) - Student ? Y / N Full Time / Part Time

(Please Circle All That Apply)

For Billing and Collection use only: ☐ Insurance Complete ☐ PIP Application ☐ Signature ☐ Non-Owner Affidavit

Verified By: On: Chart #: