



## CONSENT TO TREAT

I, the undersigned, voluntarily give consent to Medical Center Affiliates professional to provide and perform such medical/diagnosis/minor surgical treatment (s) and/or services as deemed advisable and necessary for the diagnosis and/or treatment of my condition(s) or to maintain my health. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in this office.

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Patient Printed Name Date Date of Birth

\_\_\_\_\_  
**Signature of Patient/Legal Representative**

.....

### RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I have received/reviewed a copy of Medical Center Affiliates' Notice of Privacy Practices and the Florida Patient Bill of Rights.

\_\_\_\_\_  
**Signature of Patient/Legal Representative** Date

### FOR OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so for the reason documented below:

Date _____ Initials _____ Reason _____
--

### Authorization and Assignment

I hereby authorize Medical Center Affiliates practice to release any medical information necessary to process all claims for reimbursement on my behalf: I authorize payment to be made directly to Medical Center Affiliates for services rendered. I also authorize payment of government benefits to the physician (entity) and any payments related to crossover insures. I request that payment of authorized secondary insurance be made either to me or on my behalf to the above names entity. I understand that I am financially responsible for all charges if. they are not covered by my insurance. In the event of default, I agree to pay all cost of collections and reasonable attorney's fees. I certify that the information I have reported with regard to my insurance coverage is correct. I further agree that a photocopy of this agreement shall be considered effective and valid as the original.

\_\_\_\_\_  
**Signature of Patient/Legal Representative** Date



## NOTICE OF PRIVACY PRACTICES

Our practice is committed to educating our patients about healthcare issues that affect them. As a result, we are providing you with general information about the Privacy Rule, a federal regulation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) along with a brief overview of our Notice of Privacy. Our practice does comply with HIPAA regulations.

**What is HIPAA and how does the Privacy Rule affect you?** The Health Insurance Portability and Accountability Act of 1996 (HIPAA) gave the federal government the ability to mandate how healthcare plans, providers, and clearinghouses store and send a patient's personal information as it relates to healthcare. The Privacy Rule was created to protect your rights as a patient of our practice and we are required by law to comply with the regulation. Under the Privacy Rule, you are guaranteed access to your medical records, allowed control over how your protected health information is used and disclosed and allowed to take action if your privacy is compromised by following the practice's policy. Our practice is dedicated to maintaining the privacy of your personal information.

**What is Individually Identifiable Health Information?** Any health information you provide to our practice, including your mailing address. Information that is created and retained by our practice or received from another healthcare provider that relates to your treatment, healthcare operations, payment and /or that identifies you as an individual.

**What is the Notice of Privacy Practice?** Our official Notice of Privacy Practice is posted in our reception area and informs our patients about their rights surrounding the protection of their Individually Identifiable Health Information and our obligations concerning the use and disclosure of such information. This notice applies to all records created, obtained or retained by our practice. We may update our Notice of Privacy Practices at any time. Our Notice of Privacy Practice will be posted in our reception area and you may ask for a copy at any time.

The following categories describe the circumstances in which we may use and disclose your Individually Identifiable Health Information:

Treatment	Appointment Reminders
Payment	Health Care Operations
Treatment Options	Disclosures required by law
Health-related benefits and services	Release of information to Family/Friends



The following categories describe unique situation in which we may disclose your individually Identifiable Health Information:

- |                                 |                                     |
|---------------------------------|-------------------------------------|
| Public Health Risks             | Health Oversight Committees         |
| Lawsuits and Similar Activities | Deceased Patients                   |
| Organ and Tissue Donation       | Serious Threats to Health or Safety |
| Military                        | National Security Inmates           |
| Worker's Compensation           | Law Enforcement                     |
| Research                        |                                     |

**What are your rights concerning your Individually Identifiable Health Information?** You have rights regarding the Individually Identifiable Health Information that we maintain about you. The policies and procedures for the following circumstances are listed in our Notice of Privacy Practices:

1. Confidential Communications
2. Requesting Restrictions
3. Inspection and Copies
4. Amendment
5. Accounting of Disclosures
6. Right to a Paper Copy of this Notice
7. Right to File a Complaint
8. Right to Provide an Authorization for Other Uses and Disclosures

**I have read the short notice provided by Physician Care Centers and have been informed of how to obtain more information regarding the practice's Notice of Privacy.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date



## PATIENT SELF-DETERMINATION QUESTIONNAIRE

### YOUR RIGHT TO DECIDE

PATIENT NAME: \_\_\_\_\_ DOB \_\_\_\_\_

While you cannot remove all uncertainty about your future health care needs, having an ADVANCE DIRECTIVE in place can give you the peace of mind that comes from making your wishes known in advance.

#### Declaration to Decline Life-Prolonging Procedures

- I have made a Living Will
- I do NOT have a Living Will

#### Health Care Surrogate

- I have designated a Health Care Surrogate
- I have NOT designated a Health Care Surrogate

#### Durable Power of Attorney

- I have appointed a Durable Power of Attorney for Health Care Decisions
- I have NOT appointed a Durable Power of Attorney for Health Care Decisions

If you have a living will and/or an assigned health care surrogate, we will gladly make a copy of your documents and place it in your chart.

### PATIENT PRIVACY QUESTIONNAIRE

- I. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations):

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Relationship: \_\_\_\_\_ Relationship: \_\_\_\_\_

- II. Please list the family members or significant others, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

- III. Please indicate your understanding that all correspondence from our office will be sent in a sealed envelope marked "CONFIDENTIAL":  Check here to indicate that this statement was read.

- IV. Can confidential messages (i.e. appointment reminders) be left on your telephone answering machine or voicemail?

Yes  No

- V. Please print the phone number you want to receive calls about your appointments \_\_\_\_\_

I am fully aware that a cell phone is not a secure and private line.

Signature Patient/legal Representative: \_\_\_\_\_ Date: \_\_\_\_\_



**PATIENT'S PERSONAL HISTORY & HEALTH ASSESSMENT**

Name (Last, First, M.I.):				<input type="checkbox"/> M <input type="checkbox"/> F	DOB:
Address:				SOC.SEC #:	
City:	State:	Zip Code:	Phone: ( )		
Employer:		Employer Phone:			
Nearest Relative:		Relationship:	Address:		
City:	State:	Zip Code:	Phone :( )	Work: ( )	
Date of last physical exam:		Previous or referring doctor:		Phone ( )	

**PERSONAL HEALTH HISTORY (CHECK IF YOU USE OR HAVE ANY OF THE FOLLOWING)**

<b>Medical Equipment:</b>	<input type="checkbox"/> Cane	<input type="checkbox"/> Oxygen	<input type="checkbox"/> Catheter	<input type="checkbox"/> Walker	Do you use: Glasses _____ Hearing Aid _____
	<input type="checkbox"/> Wheelchair	<input type="checkbox"/> Nebulizer			
<b>Social History of:</b>	<input type="checkbox"/> Alcohol		<input type="checkbox"/> Other		
	<input type="checkbox"/> Smoking				
	<input type="checkbox"/> Drugs		RELIGION:		
<b>Marital Status:</b>	Married <input type="checkbox"/>	Widowed <input type="checkbox"/>	Single <input type="checkbox"/>	Divorced <input type="checkbox"/>	Separated <input type="checkbox"/> Live Alone <input type="checkbox"/>
<b>Immunizations and dates:</b>	<input type="checkbox"/> Tetanus		<input type="checkbox"/> Pneumonia		
	<input type="checkbox"/> Hepatitis		<input type="checkbox"/> Chickenpox		
	<input type="checkbox"/> Influenza		<input type="checkbox"/> MMR <i>Measles, Mumps, Rubella</i>		
<b>FAMILY HISTORY</b>	<b>ALIVE</b>	<b>DEAD</b>	<b>AGE</b>	<b>CAUSE OF DEATH</b>	
MOTHER					
FATHER					
BROTHER					
SISTER					

**CHECK IF YOU HAVE/HAD ANY OF THE FOLLOWING ILLNESSES. (IF UNSURE, LEAVE BLANK)**

	Yes	No	Any Relative		Yes	No	Any Relative		Yes	No	Any Relative
Alcohol Overuse				Epilepsy				Radiation Treatment			
Allergies				Frequent Kidney/Bladder Infections				Rheumatic Fever			
Anemia				Gallbladder Disease				Sexually Transmitted D.			
Arthritis				Goiter				Sickle Cell Anemia			
Asthma				Gout				Stomach Ulcers			
Bleeding Tendency				Hay Fever				Stroke			
Cancer				Heart Attack				Suicide Attempt			
Chicken Pox				Intestinal Polyps				Thyroid			
Colitis				Jaundice				Tuberculosis			
Congenital Heart Disease				Leukemia				Whooping Cough			
Depression				Measles				Other			
Diabetes				Migraine							
Dialysis				Mumps							
Emphysema				Nervous Breakdown							

**OPERATIONS:** *List and indicate approximate year*

Year	Reason	

**HOSPITALIZATIONS:** *Other than operations, especially in the last year*

Year	Reason	

**SERIOUS INJURIES:** *Other than above*


**MEDICATIONS:** *(Check if take any of the following)*

Asthma wheezing medication	<input type="checkbox"/>	Insulin or Diabetic pills	<input type="checkbox"/>	Weight-reducing pills	<input type="checkbox"/>
Aspirin, Bufferin, Anacin, Tylenol or other	<input type="checkbox"/>	Anemia medicine	<input type="checkbox"/>	Blood thinners or Coumadin	<input type="checkbox"/>
Blood Pressure Pills	<input type="checkbox"/>	Laxatives	<input type="checkbox"/>	Dilantin	<input type="checkbox"/>
Cortisone, Prednisone	<input type="checkbox"/>	Motrin, Advil, Ibuprofen	<input type="checkbox"/>	Diuretics, water pills	<input type="checkbox"/>
Cough Medicine	<input type="checkbox"/>	Sleeping Pills, Tranquilizer	<input type="checkbox"/>	Antibiotics	<input type="checkbox"/>
Digitalis or Heart Medicine	<input type="checkbox"/>	Thyroid Medicine	<input type="checkbox"/>	Phenobarbital/barbiturates	<input type="checkbox"/>
Hormones	<input type="checkbox"/>	Stomach/Digestive Medicine	<input type="checkbox"/>	Vitamins	<input type="checkbox"/>

**List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers**

Name the Drug	Strength	Frequency Taken

**Allergies to medications**

Name the Drug	Reaction You Had

**PLEASE BRING ALL MEDICINES YOU ARE TAKING TO EVERY VISIT!**



Patient Name: \_\_\_\_\_

DATE: \_\_\_\_\_

**REVIEW OF SYSTEMS**

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

<b>General</b>	Do you usually feel persistently tired or worn out?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you recently been drinking more water or fluids?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Has there been any unusual weight gain or loss recently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Cardiovascular</b>	Do you have pain, tightness or pressure in the front or back of your chest?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have any swelling of your feet or ankles?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you been told your electrocardiogram was abnormal?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Does your heart ever beat fast or irregularly?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have cramps in the calf muscles when you walk?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do your fingers or toes ever get cold, become numb, or get very white or bluish?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Central Nervous System</b>	Do you have frequent or severe headaches?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you often have spells of dizziness, faintness or hotheadedness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you sometimes lose the ability to speak?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you recently fainted, blacked out, lost consciousness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have trouble remembering recent events?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you ever have convulsions or fits?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you ever wanted to commit suicide?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you ever hear voices or see people when no one is around?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>EYES</b>	Have you had any pain in your eyes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you had Glaucoma?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you had blurry vision?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you had halo around lights?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you had change in vision?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you had cataracts or implants?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you wear glasses?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	When did you last see an eye doctor?		
<b>ENT</b>	Do you have any trouble hearing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Any trouble ringing or buzzing in your ears?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have earaches or discharge from your ears?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have frequent or severe nose bleeds?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have persistent hoarseness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have bleeding gums?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you use a hearing aid?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

<b>Personal Safety</b>	Do you live alone?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have frequent falls?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have vision or hearing loss?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have an Advance Directive or Living Will?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Would you like information on the preparation of these?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**FAMILY HEALTH HISTORY**

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
<b>Father</b>			<b>Children</b>	<input type="checkbox"/> M <input type="checkbox"/> F	
<b>Mother</b>				<input type="checkbox"/> M <input type="checkbox"/> F	
<b>Sibling</b>	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F		<b>Grandmother</b> <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		<b>Grandfather</b> <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		<b>Grandmother</b> <i>Paternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		<b>Grandfather</b> <i>Paternal</i>		

**MENTAL HEALTH**

Is stress a major problem for you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel depressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you panic when stressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have problems with eating or your appetite?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you cry frequently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever attempted suicide?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever seriously thought about hurting yourself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have trouble sleeping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been to a counselor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No



**WOMEN ONLY**

Age at onset of menstruation:		
Date of last menstruation:		
Period every ____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Number of pregnancies ____ Number of live births ____		
Are you pregnant or breastfeeding?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had a D&C, hysterectomy, or Cesarean?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any urinary tract, bladder, or kidney infections within the last year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any problems with control of urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any hot flashes or sweating at night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Experienced any recent breast tenderness, lumps, or nipple discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last pap and rectal exam?		

**MEN ONLY**

Do you usually get up to urinate during the night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, # of times ____		
Do you feel pain or burning with urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel burning discharge from penis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the force of your urination decreased?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any problems emptying your bladder completely?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any difficulty with erection or ejaculation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any testicle pain or swelling?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last prostate and rectal exam?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**OTHER PROBLEMS**

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

<input type="checkbox"/> Skin	<input type="checkbox"/> Chest/Heart	<input type="checkbox"/> Recent changes in:
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Back	<input type="checkbox"/> Weight
<input type="checkbox"/> Ears	<input type="checkbox"/> Intestinal	<input type="checkbox"/> Energy level
<input type="checkbox"/> Nose	<input type="checkbox"/> Bladder	<input type="checkbox"/> Ability to sleep
<input type="checkbox"/> Throat	<input type="checkbox"/> Bowel	<input type="checkbox"/> Other pain/discomfort:
<input type="checkbox"/> Lungs	<input type="checkbox"/> Circulation	

<b>Have you ever had a blood transfusion?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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## Authorization to Release Information

Patient Name: \_\_\_\_\_ SSN# \_\_\_\_\_

Address: \_\_\_\_\_

DOB: \_\_\_\_\_ Phone: \_\_\_\_\_

I authorize \_\_\_\_\_ to release copies of my medical records to:

### **PCC Medical Holding**

Dr. \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

**A.)** I authorize release of information for:

\_\_\_\_ Medical Care (physicians, etc.)    \_\_\_\_ Personal Use    \_\_\_\_ Other: (Attorney, Insurance, Employer, etc.)

**B.)** I am transferring from medical office \_\_\_\_\_ to \_\_\_\_\_

**C.)** I authorize release of my (*refer to section D, if applicable*) \_\_\_\_\_ Entire medical record

**-OR-**

Medical Records for the specific treatment dates from \_\_\_\_\_ to \_\_\_\_\_

**D.)** I authorize release of the following portions of my medical record:  
(*initial beside each area to be included in release*)

\_\_\_\_ Mental Health    \_\_\_\_ Substance Abuse    \_\_\_\_ HIV/AIDS    \_\_\_\_ Communicable Disease

I understand that this authorization shall be in effect for 180 days following the date of signature. However, I understand that this authorization may be revoked at any time by giving oral or written notice to the medical office. A photocopy of this authorization shall constitute a valid authorization. I understand that once my records have been released, the medical office cannot retrieve them and has no control over the use of the already released copies.

Should my case require review by a governing agency or another medical professional actively involved in my care to make a final determination, it is with my consent that a copy of these records will be submitted to the agency or medical professional for review.

\_\_\_\_\_  
Patient/legal representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

**NOTICE:** The information has been disclosed to you from records whose confidentiality has been protected by federal and state law. You are prohibited from making further disclosures of such information without specific consent of the person to whom such information pertains or as otherwise permitted by state law. A general authorization is NOT sufficient for this purpose.



## Billing Demographics Sheet

Location: \_\_\_\_\_ Physician: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Home Street Address: \_\_\_\_\_

City, State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Widow \_\_\_\_\_ Divorced

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

### Emergency Contact - *(Not Living With You)*

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_

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### Insurance Information

Primary Insurance: \_\_\_\_\_ Phone: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

ID Number: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Subscribers Name: \_\_\_\_\_ Group Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security: \_\_\_\_\_

Employer: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Phone: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

ID Number: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Signature of Patient or Responsible Party for Payment: \_\_\_\_\_

Print Name of Patient or Responsible Party for Payment: \_\_\_\_\_

Office Use:

**ATTACH A COPY OF THE FRONT AND BACK OF ALL INSURANCE  
& IDENTIFICATION CARDS**