

Florida Infectious Disease Group, P.A.

PATIENT REGISTRATION

Please Print

Patient: *This section refers to patient only*

NAME: _____
BIRTHDATE: ____/____/____ SEX: ____ AGE: ____ Marital Status: ___ Single ___ Married ___ Divorced
SOCIAL SECURITY # _____ ___ Separated ___ Widowed
ADDRESS: _____
CITY STATE ZIP
HOME PHONE #: () _____ WORK PHONE #: () _____ OCCUPATION _____
EMPLOYER: _____ EMPLOYER ADDRESS: _____
Primary care Physician/Referring: _____ Phone#: () _____

Billing:

Primary Insurance Co. _____ Billing Address: _____
ID # _____ Group # _____ Subscriber: ___ Self ___ Other
Secondary Insurance Co. _____ Billing Address: _____
ID# _____ Group # _____ Subscriber: ___ Self ___ Other

Please complete if Subscriber is other than the patient:

Relation to patient: _____ NAME: _____
BIRTHDATE: ____/____/____ SEX: ____ AGE: _____ SOCIAL SECURITY # _____
ADDRESS: _____
CITY STATE ZIP
HOME PHONE #: () _____ WORK PHONE #: () _____

DESCRIPTION OF CONDITION: _____

ALLERGIES: _____

PRESENT MEDICATIONS: _____

Date of Injury _____ Date last worked: _____ Date returned to work: _____

Work Related Injury? Yes _____ No _____ If yes, Claim # _____

Worker Comp Carrier: _____ Adjuster's name, #: _____

IN CASE OF EMERGENCY, Please provide us with name, relation and number to contact:

I authorize my insurance carrier to pay directly to *Florida Infectious Disease Group, P.A.* all charges for services rendered me by them. I understand that I will be responsible for any and all charges not paid by my insurance company. I authorize *Florida Infectious Disease Group, P.A.* to release all information concerning my medical condition to my insurance carrier or attorney, for the purpose of Processing a claim.

Date: _____ Signature: _____

MEDICARE LIFETIME ASSIGNMENT

Name of Beneficiary: _____ Medicare Number: _____

I request that payment of authorized Medicare benefits be made to me or on my behalf to FLORIDA INFECTIOUS DISEASE GROUP, P.A. for any services furnished to me by that provider. I authorize any holder of medical information about me to release to the health care financing Administration and its agents any information needed to determine benefits payable for related services. This authorization is in effect until I choose to revoke it.