Name_____
Local Address_____City_____State_____Zip Code_____
Northern Address_____City_____State_____Zip Code_____
Home Phone (_____)_____Northern Home Phone (____)_____Cell (_____)_____
Social Security_____ Date of Birth_____ Marital Status_____
Spouse's Name_____ Date of Birth _____
Email Address _____How did you learn of our practice? _____
Were you referred by a Doctor? Y N DR _____

EMPLOYMENT INFORMATION
Name_____Phone_____
Military History_____ Level of Education_____

INSURANCE
IF TRADITIONAL MEDICARE IS YOUR PRIMARY INSURANCE, WHICH ADDRESS DOES MEDICARE HAVE ON FILE FOR YOU? _____FLORIDA _____NORTHERN

As a courtesy we will file to your secondary insurance if Medicare does not cross over. If your secondary carrier does not pay within 30 days you will be responsible for payment.

LOCAL EMERGENCY CONTACT (not living with you)

Name_____Phone_____

*****PRIVACY ACKNOWLEDGEMENT*****
Our office will keep all of your medical records private and confidential as per the government regulations. If you have any questions, please notify one of our staff members.

I REQUEST / DECLINE (circle one) a copy of the Notice of Privacy Practices. I understand a copy of the privacy policy will be given to me upon request at any time, and is also available on the website and is displayed in the lobby.

Signature: _____

****IF YOU WOULD LIKE TO GIVE PERMISSION FOR US TO DISCUSS OR RELEASE YOUR MEDICAL/FINANCIAL RECORDS, PLEASE LIST NAME AND RELATIONSHIP BELOW.**

*Name*_____ *Relationship*_____

*Name*_____ *Relationship*_____

*Name*_____ *Relationship*_____

RELEASE OF AUTHORIZATION/ASSIGNMENTS OF BENEFITS
I authorize the release of any medical information necessary to process my insurance claim(s). I authorize and request payment of medical benefits directly to my physicians. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me. I agree that a photocopy of this form may be used in place of the original.

X_____ **Date**_____
(Signature of Patient)
X_____ **Date**_____

X_____ **Date**_____