FAMILY MEDICAL CENTER

2863 S. Delaney Avenue • Orlando, FL 32806

Date: _______ /_______ /_________

Thank you for choosing our office. In order to serve you better, please print the following.

Patient's Last Name: ___________________________________ First: ________________________________ Middle Initial: ______

Mailing Address: ____

City: ____ State: _________ Zip: ______________ SS#: _________________________

Sex: ___M ___F Home Phone: _____________________ Work: _____________________ Cell: ______________________

Date of Birth: ___________________ Age: _____________ Employer: ____

Marital Status: ___M ___S ___Div ___W Spouse/Parent: ____

Spouse/Parent Employer:____ Work Phone: __________________________

Email: ____ Preferred Method of Contact: ___Phone ___Mail ___Email

Race: ___Caucasian ___Hispanic ___African American ___Other ____

Ethnicity: ___Hispanic ___Non Hispanic ___Declined

PRIMARY INSURANCE COMPANY NAME ____

Policy Holder's Name: ______________________________________ D.O.B._________________ SS#_______________________

Relationship to Patient: ______________________________ ID#__________________________ Group #_____________________

SECONDARY INSURANCE COMPANY NAME ____

Policy Holder's Name: ______________________________________ D.O.B._________________ SS#_______________________

Relationship to Patient: ______________________________ ID#__________________________ Group #_____________________

NEAREST RELATIVE NOT IN HOUSEHOLD / OR EMERGENCY CONTACT

Name: ____ Relation:__________________ Home Phone: _________________________

Signature: __________________________________ **By signing you agree to allow your provider to access your prescription history.**

Advanced Directive: All adults in health care settings in the state of Florida have the right to an "advanced directive". This is a written or oral statement made and witnessed in advance of a serious illness or injury, stating how medical decisions will be made. An advanced directive enables you to state your choice or name someone to make your choice for you, if you should become unable to make decision about your medical treatment. An advanced directive can enable you to make decisions. Do you have a Living Will? ____Yes ____ No (If yes, please provide this office with a copy. If no, and you would like a living will, we have one available.)

Signature: ____ **Date:** ____________________________________

I authorize the release of medical information necessary to obtain payment of medical benefits from my health insurance company.
I also authorize my insurance company to pay Family Medical Center any medical benefits due for services rendered.
I understand that I am responsible to pay deductibles, co-pays and any other charges not paid by my insurance company.
CO-PAYMENTS AND DEDUCTIBLES ARE DUE AT THE TIME OF YOUR OFFICE VISIT.
Our policy is that payment is expected in full at the time services are rendered, unless other financial arrangements are made **in advance**. If you participate with one of our contracted insurance programs, we will bill your insurance company. Verification of your insurance, deductible, and co-payment in advance of your office visit will be necessary. To the best of my knowledge, the above information is correct. I understand and agree to comply with the practice's financial policy.

Signature: ____ **Date:** ____________________________________

Print Name: ____