PLEASE FILL OUT COMPLETELY. THIS INFORMATION IS ESSENTIAL TO EXPEDITE YOUR CARE.

PATIENT INFORMATION (PRINT CLEARLY)

LAST NAME_____ FIRST NAME_____ DATE OF BIRTH_____

ADDRESS_____ CITY_____ STATE_____ ZIP CODE_____

PRIMARY NUMBER_____ ALT. NUMBER_____ SS#_____ M____ F____

RACE_____ ETHNICITY_____ PRIM LANG_____ MARITAL STATUS_____

EMPLOYER NAME_____ ADDRESS_____

EMPLOYER PHONE NUMBER_____ OCCUPATION_____

SPOUSE NAME _____ DATE OF BIRTH_____ SS#_____

SPOUSE EMPLOYER NAME & PHONE #_____

PRIMARY INSURANCE

LAST NAME_____ FIRST NAME_____ DATE OF BIRTH_____

RELATIONSHIP TO PATIENT_____ SOCIAL SECURITY_____

INSURANCE NAME_____

INSURANCE ID NUMBER_____ GROUP#_____

SECONDARY INSURANCE

LAST NAME_____ FIRST NAME_____ DATE OF BIRTH_____

RELATIONSHIP TO PATIENT_____ SOCIAL SECURITY_____

INSURANCE NAME_____

INSURANCE ID NUMBER_____ GROUP#_____

Insurance release: I hereby authorize Medical Diagnostic Associates, P.A. to release information acquired in the course of medical examination or treatment to my insurance carrier and to file my health insurance claims for services rendered.

SIGNATURE_____ **DATE**_____

MEDICARE PATIENTS ONLY: I hereby authorize direct payment to Medical Diagnostic Associates., P.A. for services billed on assigned basis.

SIGNATURE_____ **DATE**_____

REFERRING PHYSICIAN:

NAME_____

ADDRESS:_____

_____

PHONE:_____

PRIMARY CARE PHYSICIAN:

NAME_____

ADDRESS:_____

_____

PHONE:_____

EMERGENCY CONTACT PERSON:

NAME_____

ADDRESS:_____

_____

PHONE:_____

PHARMACY:

NAME_____

ADDRESS:_____

_____

PHONE:_____

SIGNATURE_____ **DATE**_____