ARTHRITIS CENTER *of* ORLANDO

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Thank you for choosing Arthritis Center *of* Orlando; in order to better serve you, please print, complete, and bring to your appointment the following information:

PATIENT NAME: Last _____ First _____MI_____

ADDRESS: _____ City_____ State_____ Zip_____

Cell: _____Home: _____Work: _____

Email address: _____
(We will not release patient information via email)

SEX: __M__F DOB: _____/_____/_____ AGE____ MARITAL STATUS: ___Single ___ Married ___ Divorced ___ Widowed

PATIENT SS#: _____/_____/_____ OCCUPATION_____

Employer_____ Spouse Name: _____

Spouse Phone # _____

INSURANCE INFORMATION - PLEASE PROVIDE INSURANCE CARD & DRIVER'S LICENSE

Name of Insurance: _____Policy holder_____ Insured DOB: ____/____/_____
Insured's SSN# ____/____/_____

SECONDARY INS. INFO
Name of Insurance: _____Policy holder_____ Insured DOB: ____/____/_____
Insured's SSN# ____/____/_____

Name of Primary Care Physician:_____ Name of Referring Physician:_____

Emergency contact name: _____Relationship_____Phone_____

Address_____ City_____ State _____ Zip_____

Can we call you at work with appointment information or test results? **(Circle one)** YES NO
Can we leave messages on voice mail or mail health related information to you from our office? **(Circle one)** YES NO

TO WHOM DO YOU AUTHORIZE ARTHRITIS CENTER *OF* ORLANDO TO RELEASE MEDICAL INFORMATION?

Name: _____ Relationship: _____

Patient Signature: _____ Date: _____

I consent to treatment and authorize the release of protected health information (PHI) necessary for treatment and obtaining payment of medical benefits from my health insurance company. I authorize my insurance company to pay Arthritis Center of Orlando any medical benefits due me for their services. I understand I am responsible to pay deductibles, co-pays and other charges not paid by my insurance company. Our policy is that payment is expected in full at 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. CO-PAYMENTS AND DEDUCTIBLES ARE DUE AT THE TIME OF YOUR OFFICE VISIT. Therefore, verification of your insurance, deductible, and co-payment in advance of your office visit will be necessary. A copy of Arthritis Center *of* Orlando Privacy Practices is available to me for review at my request.

Signature: _____ Date_____

Print Name: _____