ARTHRITIS CENTER *of* ORLANDO
1550 Citrus Medical Court
Ocoee, FL 34761
Tel 407 570 2777 Fax: 407 757 0271

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 any information via email. This is for portal registration only)

SEX: __M__F **DOB:** _____/_____/_____ **AGE**___

PATIENT SS#: ___/___/_____

Emergency contact name:____________Relationship__________________Phone____________________

Address: _______________________ City______________________ State _________ Zip__________

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

PRIMARY INSURANCE:
Name of insurance: _________________ Policy Holder: ______________Relationship to Patient:________
Insured DOB: _____/_____/_____ Insured's SS#: ___/___ /____

SECONDARY INS: ______________ Policy Holder: _____________ Relationship to Patient:
_____________________ I
Insured DOB: _____/_____/_____ Insured's SS#: ___/___ /____

Name of person making referral________________

Name of Primary Care Physician:_____________________
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

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.

Signature: ____ Date________________