MEDICAL ASSOCIATES OF BREVARD

PATIENT INFORMATION

PATIENT'S NAME_____
(LAST) (FIRST) (MI) (NICKNAME)

DOB____/____/_____ SOCIAL SECURITY# _____-_____-_____ MARITAL STATUS_____ ☐ MALE ☐ FEMALE

ADDRESS_____
(STREET) (CITY,STATE) (ZIP CODE)

HOME PHONE(____) _____-_____ CELL PHONE(____) _____-_____ WORK PHONE(____) _____-_____

EMERGENCY CONTACT_____ PATIENT'S EMPLOYE_____

RELATIONSHIP TO PATIENT_____ PATIENT'S EMAIL ADDRESS_____

EMERGENCY CONTACT PHONE # (_____) _____-_____

REFERRING PHYSICIAN_____ FAMILY DOCTOR_____ PHONE# (____)_____-_____

INSURANCE INFORMATION

PRIMARY INSURANCE CO._____ POLICY #_____

NAME OF INSURED PARTY_____ DOB:_____ S.S #_____-_____-_____

SECONDARY INSURANCE CO._____ POLICY #_____

NAME OF INSURED PARTY_____ DOB:_____ S.S. #_____-_____-_____

I understand that I am financially responsible for all charges for services to me, including co-payments, co-insurance, out-of-pocket and deductibles. I authorize payment of medical benefits and I assign benefits payable to Medical Associates of Brevard for professional services rendered. I understand that I will receive statements, reflecting my account balance and that the FINAL PAYMENT of this account is my responsibility. Furthermore, should I default on payment for services rendered I agree to pay all collection costs including reasonable attorney's fees. Please be advised that your insurance has been verified but is not a guarantee of payment. This signature and assignment is to be a continuing one, remaining in effect until revoked in writing by the undersigned.

SIGNED_____ DATE_____/_____/_____

HIPPA RELEASE

I authorize Medical Associates of Brevard to discuss my health care with and/or leave a detailed message on my answering machine:

_____ _____
(NAME) (RELATIONSHIP)

_____ _____
(NAME) (RELATIONSHIP)

SIGNED_____ DATE_____/_____/_____