



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 ____/____/____