Rheumatology Associates Central Florida

3160 Southgate Commerce Blvd Ste 30
Orlando, FL 32806-8557
(407) 859-4540

PATIENT INFORMATION

NAME (Last, First Middle)	MRN	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	SECONDARY/BILLING ADDRESS (if Applicable)	ETHNICITY

CITY, STATE ZIP	HOME PHONE	CITY, STATE ZIP	HOME PHONE	RACE

PRIMARY CARE PHYSICIAN	REFERRING PHYSICIAN	CONTACT NAME	CONTACT HOME PHONE

PRIMARY EMPLOYER	SECONDARY EMPLOYER (if Applicable)
ADDRESS	ADDRESS
CITY, STATE ZIP	CITY, STATE ZIP
WORK PHONE	WORK PHONE

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	SECONDARY/BILLING ADDRESS (if Applicable)
CITY, STATE ZIP	CITY, STATE ZIP
HOME PHONE	HOME PHONE
RELATIONSHIP TO PATIENT	

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY	POLICY#	
NAME OF INSURED	GROUP#	
ADDRESS OF INSURANCE COMPANY	COPAY AMT	
	$	
CITY, STATE ZIP	DEDUCTIBLE	
	$	
RELATIONSHIP TO PATIENT	EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY		POLICY#	
NAME OF INSURED	SSN#	BIRTHDATE	GROUP#
ADDRESS OF INSURANCE COMPANY		COPAY AMT	
		$	
CITY, STATE ZIP		DEDUCTIBLE	
		$	
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

PATIENT RELEASE:

I Certified the information I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare), or purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider. I ACKNOWLEDGE THAT INTEREST OR A FEE, AT THE PROVIDERS CURRENT RATE MAY BE CHARGED on all balances owing to the provider that are past due. I permit a copy of this release to be used in place of the original.

SIGNATURE OF PATIENT/GUARDIAN _____ DATE _____