Patient Information

Please answer all questions fully

Date:

Account Number:

Rheumatology Associates Of Cntrl Fl. P.A
3160 Southgate Comm Blvd Ste 30
Orlando, FL 32806-8557

Phone: (407) 859-4540 Fax: (407) 859-3815

Patient						
Name (Last, First, MI)	Social Security	Age	Birthdate	Sex	Race	Home Phone

Mailing Address	City	State	Zipcode	Marital Status
Employer	City	State	Zipcode	Work Phone

Responsible Party				
Name (Last, First ,MI)	Social Security	Birthdate	Sex	Home Phone

Address	City	State	Zipcode	Marital Status
Employer	City	State	Zipcode	Work Phone

Primary Provider	**Referring Provider**	**Referring Address**	**Phone**	**Fax**

Insurance Information				
Primary Insurance Company	Subscriber's Name, Birthdate, SSN	Relationship	Policy Number/Group#	Copay
Second Insurance Company	Subscriber's Name, Birthdate, SSN	Relationship	Policy Number/Group#	Copay
Third Insurance Company	Subscriber's Name, Birthdate, SSN	Relationship	Policy Number/Group#	Copay

Emergency Contact Information			
Contact Name	Relationship	Primary Phone Number	Secondary Phone Number

Please List Additional Medical Information

Patient Release:
I certify the information that 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), for 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 PROVIDER'S 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: _____ Date: / / 2013

(Signature of insured or authorized person, patient or parent if minor)