Patient Information

Please fill in all blanks and verify that all printed information is true and accurate

Have you been here before? Yes No
Appointment Date: _____

Do you own or rent? Rent Own
Have you had x-rays for this problem? Yes No
Doctor Seen Today: _____

PATIENT

Patient ID: _____
Name: _____
Address: _____
_____
City: _____ State: ___ Zip: _____

Birth Date: _____
Age: _____
SSN: _____
Home Phone: _____
Marital Status: _____
Cell Phone: _____

EMPLOYMENT/EMPLOYER

Work Place: _____
Address: _____
City: _____ State: _____ Zip: _____

Work Phone: _____

PATIENT CONTACTS

Emergency Contact Name: _____
Parent, Guardian, Spouse, Other: _____
Employer: _____

Emergency Phone: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____

PRIMARY INSURANCE

Name of Policyholder: _____
Birth Date of Policyholder: _____
Insurance Company: _____
Address for Claims: _____
City: _____ State: _____ Zip: _____
Insurance Company Phone Number: _____

ID#: _____
SSN of Policyholder: _____
Group #: _____

SECONDARY INSURANCE

Name of Policyholder: _____
Birth Date of Policyholder: _____
Insurance Company: _____
Address for Claims: _____
City: _____ State: _____ Zip: _____

ID#: _____
SSN of Policyholder: _____
Group #: _____

I hereby certify that the above information is true and accurate. Further, I certify that I have received and read the Orthopaedic Clinic of Daytona Beach, P.A., Patient Information Brochure and Notice of Privacy Practices. In accordance with Florida Statue 627.736(5), I agree to pay all applicable deductibles and co-pays. By my signature, I understand and agree to the terms set forth herein.

Patient Signature: _____ Printed Name: _____

Witness Signature: _____ Date: _____

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