INTERNET FORM

Patient Information

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

Have you been seen here before? Yes No Do you Rent or Own? Rent Own

Appointment Date: _____ Have you had x-rays for this problem? Yes No

Doctor Seen Today:_____

Patient

Patient ID: _____ Birth Date: _____

Name: _____ Age: _____

Address: _____ SSN: _____

_____ Home Phone: _____

City: _____State: _____ Zip: _____ Marital Status: _____

Cell Phone: _____

Employment/Employer

Work Place: _____ Work Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Patient Contacts

Emergency Contact Name: _____ Emergency Phone: _____

Please Circle One

Parent/Guardian/Spouse Name: _____

Address: _____

City: _____ State: _____ Zip:_____

Phone: _____

Birth Date: _____

SSN: _____

Employer: _____ Employer Phone:_____

Employer Address: _____

City: _____ State: _____ Zip:_____

Insurance

Name of Policyholder:_____ ID#: _____

Birthdate of Policyholder: _____ SSN of Policyholder: _____

Insurance Company:_____ Group #: _____

Address for Claims:_____

City:_____ State: _____ Zip: _____

Insurance Phone: _____

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. I agree to assign benefits from all applicable insurance policies (automobile, PIP & health) to the Orthopaedic Clinic of Daytona Beach, P.A. for services rendered. In accordance with Florida Statute 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 therein.

Patient Signature: _____ Printed Name: _____

Witness Signature: _____ Date: _____