SW Florida Medical Center for Age Management, Wellness and Rejuvenation

ALL INFORMATION MUST BE COMPLETED- PLEASE **PRINT** CLEARLY

Patient Information

Last Name | First Name | Middle Initial | Social Security Number

Local Street Address (No P.O. Boxes) | City | State | Zip Code

Out of State Address | City | State | Zip Code

Local Telephone Number | Cell Phone Number | Out of State Telephone Number

Date of Birth | Age | Sex | Marital Status | Driver's License Number

Employer Name | Employer's Telephone Number

Emergency Contact Person (Not Living With You) | Telephone Number | How were you referred to our office?

DO YOU HAVE AN ADVANCED DIRECTIVE (PLEASE CIRCLE)

Living Will	YES	NO	Assignment of Healthcare Surrogate	YES	NO
Do Not Resuscitate	YES	NO	Assignment of Healthcare Power of Attorney	YES	NO

Insurance Information - **As a courtesy, we will file primary and secondary insurances. Any additional insurance will be the patient's responsibility to file.**

PRIMARY

Insurance Name | Address | Telephone Number

Subscriber Name | Date of Birth | Relationship to Patient

Policy/Subscriber ID Number | Group Number | Group Name/ Employer

SECONDARY

Insurance Name | Address | Telephone Number

Subscriber Name | Date of Birth | Relationship to Patient

Policy/Subscriber ID Number | Group Number | Email address

RELEASE OF INFORMATION

I grant permission for the staff of this medical practice leave medical information, such as test results, on my answering machine. In addition, any information related to my medical care may be shared

with_____ _____ _____

Please list name and relation | Signature | Date

AUTHORIZATION FOR CARE

I grant permission to the employees of this practice to render care to the above named patient and expedite the orders of the physician and/or physician extender. I further authorize release of information to other healthcare providers associated with my care. I understand that I am responsible for any co-pay, coinsurance or deductible amount due at time of service. I also understand that I am responsible for informing this office of any change of information regarding my insurance policy. Failure to give correct information in a timely manner may result in me being responsible for the entire service rendered.

Signature Date