FLORIDA DIABETES THYROID & ENDOCRINE CENTER

Patient Information

Please Print

Last Name	*First Name*	*Middle Initial*	*Today's Date*
Street Address	*City*	*State*	*Zip Code*

Sex M F	*Employed?* Y N	*Email Address*	*SSN*	*Date of Birth*	*Home/Primary Phone #*	*Alternate Phone #*

Employer's Name	*Employer's Phone #*	*Extension Number*
Employer's Street Address	*City*	*State*	*Zip Code*

Marital Status Single Married Widowed Divorced Other	*# of Insurance Plans*	*Reason for Visit*

May we call you at home and leave a message? Y N *(PLEASE SEE BOTTOM RIGHT TO AUTHORIZE US TO SPEAK WITH OTHERS ABOUT YOUR CARE)*

How Did You Hear About Us?
Family Friend Employer Phone Book Doctor (Name)_____ Other

Do You Have a Living Will? Yes No

Insurance Information

Insurance Carrier	
Insured's Last Name	*First Name*
Address	*Insured's SS Number*
City, State, Zip, Code	*Insured's Date of Birth*
Insured's Employer Name & Address	
Relationship to Guarantor Self Spouse Parent Child Other	*Insured's Sex* M F

Secondary Carrier

Insurance Carrier	
Insured's Last Name	*First Name*
Address	*Insured's SS Number*
City, State, Zip, Code	*Insured's Date of Birth*
Insured's Employer Name & Address	
Relationship to Guarantor Self Spouse Parent Child Other	*Insured's Sex* M F

In Case of Emergency, Who Should We Call?

Name	*Relationship*	*Home or Primary Phone #*	*Alternate Phone #*
Street Address		*City, State, Zip Code*	

Consent for Treatment and Lifetime Authorization for Assignment of Benefits and Information Release

I hereby give consent to Florida Diabetes Thyroid & Endocrine Center to provide whatever treatment they deem necessary to the patient above.

Insured party must sign for all claims. Dependent patient must also sign if not a minor. I authorize any insurance company, organization, employer, hospital, physician, dentist, or pharmacist to release any information requested with regard to processing my claim. I certify that the information I furnish is true and correct.

I know it is a crime to fill out this form with facts that I know are false or to leave out facts I know are important.

I assign payment directly to the physicians of Florida Diabetes Thyroid & Endocrine Center which may be due me from the Medicare program or any other insurance company, including supplemental insurance, which may cover in whole or part medical services which I have received. I will notify Florida Diabetes Thyroid & Endocrine Center of any change in the above information.

Should the insurance information given be incorrect at time of service, I will be liable for payment of services rendered.

Signature of Responsible Person If Other Than Patient _____ ***Signature / Patient Authorization*** _____ ***Date***

Consent to use of PHI:

You have the right to review / receive a copy of our Notice of Privacy Practices before you sign this consent. By signing this form, you consent to our use and disclosure of Personal Health Information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing.

Who may we contact (family / friends) to discuss your medical care?

Please PRINT complete name(s) below:

Name	*Phone*	*Relationship*