North Florida Senior Care
Phone: (850) 391-6222 Fax (888) 698-2714

New Patient Information Form

Patient Information

Patient Name: _____ DOB: _____ Sex: _____
Driver's License: _____ SSN: _____
Home Phone: _____ Cell: _____
Address: _____
Employer: _____ Position: _____
Employer Address: _____ Phone No. _____

Emergency Contact Information

Dependent? _____ If yes, Guardian's Name: _____
Guardian's Phone: _____ Cell: _____
Marital Status: _____ Spouse's Name: _____
Spouse's Employer: _____ Work Phone No. _____
Emergency Contact: _____ Relationship: _____
Home Phone: _____ Cell: _____
Emergency Contact: _____ Relationship: _____
Home Phone: _____ Cell: _____

Insurance

Insured Party: _____ Relationship to Patient: _____
Insurance Company: _____ Phone No. _____
Address: _____
Policy No. _____ Group No. _____
Dual Coverage? _____ 2nd Insurance Company: _____
Insured Party: _____ Relationship to Patient: _____
Phone No. _____ Address: _____
Policy No. _____ Group No. _____
Payment Method: _____ Card/Check No. _____

I verify that the above information is factual and true to the best of my knowledge. I authorize the doctor to employ X-Rays, photographs, medicines, and other equipment or aids as he/she deems necessary in order to provide the proper patient care. I understand that payment, proof of insurance, and/or copay is due at the time of service.

I authorize this office to apply benefits on my behalf for the covered services rendered. I certify that the insurance information I have provided is factual and correct.

_____ _____
Patient Date