



Family Care - Specialists

DATE _____

PATIENT NAME _____ DOB / / AGE _____ SEX _____
mm d1 yy

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE # () _____ SOC. SEC. # _____ DRIVERS LIC. # _____

MARITAL STATUS: _____ MARRIED _____ SINGLE _____ OTHER _____

SPOUSE'S NAME _____

CHECK THE FOLLOWING THAT IS APPLICABLE: _____ FULL-TIME STUDENT _____ PART-TIME STUDENT

NAME OF SCHOOL: _____

EMPLOYED: (PLEASE LIST EMPLOYER) _____ PHONE # () _____

REFERRING PHYSICIAN _____

WHERE AND WHEN YOU HAVE LIVED AND TRAVELED OUTSIDE THE U.S. AND CANADA: _____

LIST OTHER ILLNESSES FOR WHICH YOU WERE HOSPITALIZED: _____

HAVE YOU HAD ANY SERIOUS INJURIES, BROKEN BONES, ETC.: _____

PREVIOUS OPERATIONS: _____

PLEASE LIST ANY MEDICATIONS YOU MAY BE ALLERGIC TO: _____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING: _____

CHECK THE DISEASE AGAINST WHICH YOU HAVE BEEN IMMUNIZED:

- 1 MMR
- 2 Tetanus
- 3 Polio
- 4 Other

In case of emergency please notify: _____

Relationship: _____

Address: _____ Phone: _____

CHECK ILLNESSES WHICH HAVE OCCURRED IN ANY OF YOUR BLOOD RELATIVES: Diabetes Cancer Bleeding Tendency
 Kidney Disease Tuberculosis Heart Disease Stroke High Blood Pressure Nervous Illness Allergy Other

CHECK ANY ILLNESS OR CONDITIONS YOU HAVE HAD Diabetes Glaucoma Heart Trouble Syphilis Vein Trouble
 Cancer Asthma Jaundice Hemorrhage Bleeding Tendencies Tuberculosis Pneumonia Kidney Disease
 Rheumatic Fever Nervous Disorder Arthritis Allergies Hypertension Other

OVER:

LIFETIME AUTHORIZATION

INSURANCE ASSIGNMENTS AND AUTHORIZATION TO RELEASE INFORMATION

I. **RELEASE OF INFORMATION** - I, the below named patient, do hereby authorize any physician examining and/or treating me to release any third party (such as an insurance company or governmental agency, example: Blue Shield of Florida or Medicare) any medical, psychiatric condition, alcohol or drug related condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for such treatment and/or diagnosis.

II. **PHYSICIAN INSURANCE ASSIGNMENT** - I, the below named subscriber, hereby authorize payment directly to any physician examining or treating me of any group and/or individual surgical and/or medical benefits herein specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charge for these services.

III. **MEDICARE/MEDICAID** - Patient's certification authorization to release information and payment request. I certify that the information given by me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration Division of Family Services or its intermediaries or carries any information needed for this of a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.

IV. **PERMIT A COPY OF THESE AUTHORIZATION AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE PHYSICIAN'S OFFICE.** This assignment will remain in effect until revoked by me in writing.

V. **CONSENT FOR TREATMENT** - I, the below named patient, hereby give my consent for treatment to all physicians associated with Family Care Specialists, Inc.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. I understand it's my responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by my insurance or third party payor within a reasonable period of time not to exceed 60 days.

If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

PATIENT: _____ Signature _____

SUBSCRIBER (if different from patient): _____ Signature _____

PLEASE PROVIDE US WITH COPIES OF YOUR INSURANCE CARDS.

MEDIGAP (SECONDARY INSURANCE) SIGNATURE

NAME OF BENEFICIARY _____

HEALTH INSURANCE COMPANY _____

MEDIGAP POLICY NUMBER _____

I request that payment of authorized MEDIGAP benefits be made on my behalf to _____ for any services furnished me by (physician/supplier). I authorize any holder of medical information about me to release to _____ any information needed to determine these benefits or the benefits payable for related services.
(Insurance Company)