PLANTATION FAMILY MEDICAL ASSOCIATES, P.A.

PATIENT REGISTRATION

SSN_____

PATIENT'S LAST NAME_____ FIRST NAME_____

ADDRESS_____

CITY_____STATE_____ ZIP CODE_____PHONE#_____

CELL#_____

DATE OF BIRTH_____ SEX: M F MARITAL STATUS S M D W

PATIENT'S EMPLOYER_____ WORK #_____

GUARANTOR'S INFORMATION (IF NOT THE PATIENT)

LAST NAME_____FIRST NAME_____

ADDRESS_____

CITY_____STATE_____ZIPCODE_____PHONE#_____

DATE OF BIRTH_____ RELATIONSHIP TO PATIENT SPOUSE CHILD OTHER

GUARANTOR'S EMPLOYER_____WORK #_____

CELL #_____

PRIMARY INSURANCE NAME_____

MEMBER#_____GROUP#_____

INSURANCE
ADDRESS_____

CITY_____STATE_____ZIP CODE_____INSURANCE PHONE #_____

SUBSCRIBER'S (IF NOT THE PATIENT)
NAME _____DATE OF BIRTH_____SSN_____

RELATIONSHIP TO THE PATIENT SELF SPOUSE CHILD OTHER

EMERGENCY CONTACT NAME AND NUMBER_____

* RELATIONSHIP TO PATIENT_____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims

PATIENT'S SIGNATURE_____DATE_____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the Physician of the Medical and /or Surgical Benefits, if any, otherwise payable to me for his services as described, realizing that I am responsible to pay non-covered services.

PATIENT'S SIGNATURE_____DATE_____