North Florida Surgeons **Account # ______________**

ALL questions must be answered completely

I. YOUR APPOINTMENT TODAY IS WITH DR. ____

Patient Name: **LAST** ____________________________ **FIRST** ___________________ **MI** ___

Sex ____ DOB ___/___/___ Age: _____ SS# ____

Person Responsible For Bill (If other than patient) ________________________________

Patient Address: ____

City ____________________ ST ______ ZIP _____________ Home Phone: ____________

Cell Phone _____________________ Email Address __________________________________

Referring Physician: ____

(PLEASE INCLUDE THE PHYSICIAN'S FIRST NAME)

Primary Care Physician: ____

(PLEASE INCLUDE THE PHYSICIAN'S FIRST NAME)

Race: White, Black, Asian/Pacific Islander, Hispanic, American Indian, Other (Please circle one)

Marital Status: Married Divorced Single Widow Separated (Please circle one)

If retired, date and place retired from: ______________________________________

Employer's Name: _________________________________ Phone #: ______________________

Employer's Address: ____

City ___________________________________ ST ______________ Zip __________________

II. PRIMARY INSURANCE COVERAGE: ____

Policy holders (subscriber's) name: ______________________________ DOB ______________

Policy holder's SS#: ___________________________ Sex: M F

Your relationship to policy holder: ____________________

Policy #: ____________________________________ GRP# ____________________________

Policy holder's employer: ____

Employer's address: _____________________________________ Phone #: _________________

SECONDARY INSURANCE COVERAGE: ____

Policy holders (subscriber's) name: ________________________________ DOB ____________

Policy holder's SS#: ___________________________ Sex: M F

Your relationship to policy holder: ____________________

Policy #: ______________________________________ GRP# ____________________________

Policy holder's employer: ____

Employer's address: ______________________________________ Phone #: ________________

III. KNOWN DRUG ALLERGIES: ____

Spouse's Name: ____

Driver's License #: ____

DO YOU HAVE A LIVING WILL: ____ Yes ____ No

Name of Emergency contact (other than spouse) _________________________________

Relationship of emergency contact person: _____________________________________

Phone #: ____________________________

I certify that, to the best of my knowledge, the above information is complete and accurate.

SIGNATURE: ____ Date: __________

Witness ____