Florida Health Care Medical Group

Patient Registration Form

Last Name: _____ First Name: _____

Street Address: _____City, State, Zip: _____

Date of Birth: _____ Gender: M or F Marital status: _____

Home Phone : _____ Cell Phone: _____ Work phone: _____

Patient place of employment: _____

Race: _____ Ethnicity _____ Preferred Language _____

Email: _____ Pharmacy: _____ Pharmacy phone number: _____

Medical Insurance Information:

Primary Insurance: _____ ID#: _____

Secondary Insurance:_____ ID#: _____

Social Security # _____

In Case of Emergency Notify:

Name:_____Phone: _____ Relationship to patient: _____

Release

I grant permission to view my prescription history from other sources.
I consent to report and receive Immunization information from the state of Florida.
I consent to have my claims filed to my insurance carrier and I understand that any balance and or copays are my reasonability and are due at the time of the visit.
I am aware that there will be a $25 charge for any no show or missed appointments without 24 notice.
I understand that it is my responsibility to notify the office if there is ever any change in my insurance coverage and or mailing address and phone number.

General consent to treat

By signing below, I or my authorized representative authorize FHCMG, physicians or practitioners and staff to conduct any diagnostic exams, tests, and procedures and to provide medication to assess, diagnose and treat my illness or injuries. I understand that it is the responsibility of my individual treating physician to explain to me the reasons for any diagnostic exam, test, procedure, the available treatment options and the common risks and anticipated burdens or benefits associated with these options as well as alternative courses of treatment.

_____ _____

Patient/Guardian Signature Date