

# Breast Care Center of Florida

## PATIENT INFORMATION PLEASE PRINT

Today's Date: \_\_\_ / \_\_\_ / \_\_\_

Patient's Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Patient's Social Security Number: \_\_\_ - \_\_\_ - \_\_\_ Date of Birth: \_\_\_ / \_\_\_ / \_\_\_ Male: \_\_\_ Female: \_\_\_

Address: \_\_\_\_\_ Apt#: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home #: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Cellular #: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Alternate Address: \_\_\_\_\_

Marital Status (check one): Single: \_\_\_ Married: \_\_\_ Divorced: \_\_\_ Widowed: \_\_\_ Separated: \_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work #: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Work (check one): Full Time: \_\_\_ Part Time: \_\_\_ Student (check one): Full Time: \_\_\_ Part Time: \_\_\_

Name of School: \_\_\_\_\_

### WHO'S RESPONSIBLE FOR PATIENT?

(Check one): Spouse: \_\_\_ Parent: \_\_\_ **If yourself, please check here**

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Social Security Number: \_\_\_ - \_\_\_ - \_\_\_ Date of Birth: \_\_\_ / \_\_\_ / \_\_\_ Home #: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Employed By: \_\_\_\_\_ Work #: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Name of Insurance: \_\_\_\_\_

### Policy Holder Information (if different from patient) If same as responsible, please check here

(Check one): Spouse: \_\_\_ Parent: \_\_\_

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Social Security Number: \_\_\_ - \_\_\_ - \_\_\_ Date of Birth: \_\_\_ / \_\_\_ / \_\_\_ Home #: ( \_\_\_\_\_ ) \_\_\_\_\_

Employed By: \_\_\_\_\_ Work #: ( \_\_\_\_\_ ) \_\_\_\_\_

Name of Insurance: \_\_\_\_\_

### EMERGENCY CONTACT (Parent/Guardian if patient is a minor)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home #: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Work #: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Please Read and Sign Next Page

**OFFICE FINANCIAL POLICY**

All professional fees are due at the time of service. All other arrangements must be made in advance.

**CONSENT FOR EVALUATION OR TREATMENT**

I hereby consent to whatever evaluation or treatment the physician may deem necessary for the patient.

**ASSIGNMENT OF INSURANCE BENEFITS**

I hereby authorize my insurance benefits to be paid directly to Florida Physicians Medical Group. I understand and agree that I am financially responsible for any balance not covered by my insurance.

**AUTHORIZATION TO RELEASE INFORMATION**

I hereby authorize the release of any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

Patient Name: \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient, Parent or Legal Guardian

\_\_\_\_\_  
Date

**MEDICARE PATIENTS ONLY**

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original. I request that payment of the authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

Patient Name: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Medicare #: \_\_\_\_\_

Date: \_\_\_\_\_

**ADVANCE DIRECTIVE**

Please provide copies of Advance Directive/Living Will to the receptionist to be included in your medical record.

I understand that the terms of any Advance Directive that I have executed will be followed by the health care facility and my caregivers to the extent permitted by law. Please check one of the following statements:

- ( ) I HAVE executed an Advance Directive.  
(Living Will, Durable Power of Attorney, Designation of a Health Care Surrogate.)
- ( ) I HAVE NOT executed an Advance Directive.  
(Living Will, Durable Power of Attorney, Designation of a Health Care Surrogate.)

Signature: \_\_\_\_\_

Date: \_\_\_\_\_