GRACE MEDICAL CENTER OF FLORIDA

Patient Information Form

Patient Information

Last Name | First Name | Middle Name

Previous Last Name | Birth Date (mm/dd/yyyy) | Sex: ❑ Male ❑ Female

Billing Address:

Street | City | State | Zip

Country

Secondary Alternate Address:

Street | City | State | Zip

Country

Please check page three (3) for Race & Language Choices:

Race | Language

Ethnicity: ❑ Hispanic ❑ Non-Hispanic ❑ Unknown Marital Status

Home Phone | Day Phone

Cell/Alternate Phone | E-Mail

Preferred Contact Method: ❑ Home Phone ❑ Day Phone ❑ Cell/Alternate Phone ❑ Email

Primary Care Physician: | How were you referred to our office?

If patient is a minor (under 18 years old):

Father's name | Mother's name

Employer Information

Employer | Occupation | Work Phone #

Employer Address:

Street | City | State | Zip

Country

Relations Information (Name of person to contact in case of an emergency):

Last Name | First Name | Relationship to Patient

Home Phone | Work Phone | Cell/Alternate Phone

Insurance

Is your visit due to an Auto Accident? ❑ Yes ❑ No If yes, date of Accident _____

Worker's Compensation? ❑ Yes ❑ No If yes, date of Accident _____

Are you personally responsible for payment of the fees for services provided by our office?

❑ Yes ❑ No

If no, who is? _____

Guarantor Name | Relationship

Address ***(if different from patient)*** | City | State | Zip Code

Country

Guarantor Employer Name

Guarantor Employer Address:

Street | City | State | Zip

Country

Employer Telephone Number | ext.

Primary Insurance Plan Name | Policy Holder Name

Policy Holder Birth Date | Policy # | Policy Group #

Secondary Insurance Plan Name | Policy Holder Name

Policy Holder Birth Date | Policy # | Policy Group #

Preferred Pharmacy #1

Name

Address | City | Phone #

Preferred Pharmacy #2

Name

Address | City | Phone #

PLEASE READ AND SIGN THE FOLLOWING

1. Payment for services is expected at time of service.
2. If insurance is filed, I authorize benefits to be paid directly to Tenet Florida Physician Services, LLC.
3. I am responsible for the balance on my account, regardless of insurance coverage. My failure to pay off outstanding balances on my account may result in collection procedures being taken.
4. I authorize the doctor to release any information requested with regard to the processing of my claims.
5. Failure to give 24 hour notice prior to canceling appointments may result in a cancellation fee charge to my account not payable by health insurance.

Patient/ Parent's/Guardian's Signature Date

Please choose from the following list for your <u>Race:</u>

Asian	Pacific Islander
Black	Unknown
Native American	White
Other Race	

Please choose from the following list for your primary <u>Language:</u>

Albanian	English	Indonesian	Portuguese	Thai
Arabic	Estonian	Italian	Romanian	Turkish
Armenian	Farsi	Japanese	Russian	Ukrainian
Azerbaijani	Filipino	Korean	Samoan	Vietnamese
Bosnian	Finnish	Laotian	Serbo-Croatian	Yiddish
Bulgarian	French	Lebanese	Sign Language	
Cambodian	German	Lithuanian	Slovak	
Chinese	Greek	Malayan	Spanish	
Creole	Haitian Creole	Norwegian	Sudanese	
Czech	Hebrew	Other	Swedish	
Danish	Hmong	Pakistan	Tagalog	
Dutch	Hungarian	Polish	Taiwanese	