GMS FLORIDA WEST COAST, INC.

FAMILY IDENTIFICATION & BUSINESS INFORMATION: DATE _____

Patient Name _____ Birth Date _____
Spouse/Parent/Guardian _____ Birth Date _____
Address _____ City _____ ST _____ Zip _____
Alternate Address _____ City _____ ST _____ Zip _____

Social Security #: _____ Marital Status:( )Married ( )Divorced ( )Widow ( )Single
Phone #: _____ Cell #: _____

Patient's Employer: _____ Occupation: _____
Phone Number: _____
Spouse's Employer: _____ Occupation: _____
Phone Number: _____

Referred By: _____

Emergency Contact: _____ Relationship: _____
Phone Number: _____ Alternate Phone Number: _____

Primary Insurance: _____ Secondary Insurance: _____
ID #: _____ ID #: _____
Covered by ( )Self ( )Spouse ( )Parent Covered by ( )Self ( )Spouse ( )Parent
Policy Holders Name: _____ Policy Holders Name: _____
Policy Holders Date of Birth: _____ Policy Holders Date of Birth: _____

Do you have Medicare? ( )Yes ( )No If Yes, Policy #: _____

You may release my medical information to:

_____ _____ _____
Name and relation Name and relation Name and relation

I give my permission to leave test results or other medically related communications on my answering machine or voice mail.
( )Yes primary #: _____ secondary #: _____ ( )No

_____
SIGNATURE OF PATIENT

PLEASE PRESENT ALL INSURANCE CARDS, COPAYMENTS AND RESIDUAL BALANCES TO THE RECEPTIONIST EACH TIME YOU COME IN TO BE SEEN.

I UNDERSTAND THAT ALL CHARGES (INCLUDING THOSE NOT PAID BY INSURANCE), COLLECTION FEES, BANK AND RETURNED CHECK FEES, LEGAL FEES AND FAILURE TO KEEP APPOINTMENT FEES ARE THE FINANCIAL RESPONSIBILITY OF THE PATIENT (OR THE PARENT/GUARDIAN IN THE CASE OF A MINOR). I HEREBY AUTHORIZE THIS OFFICE TO RELEASE ALL INFORMATION CONCERNING MY ILLNESS(ES) AND TREATMENT TO MY INSURANCE CARRIERS/HEALTH PLANS. IN THE EVENT THAT THIS OFFICE PARTICIPATES WITH MY INSURANCE CARRIER/ HEALTH PLAN, I HEREBY ASSIGN ALL AVAILABLE BENEFITS AND PAYMENTS DIRECTLY TO THEM FOR MEDICAL SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY AND ALL AMOUNTS NOT COVERED BY MY INSURANCE CARRIER/HEALTH PLAN, AND I AUTHORIZE THIS OFFICE TO CHARGE MY CREDIT/DEBIT ACCOUNT FOR THE FULL AMOUNT OF ANY UNPAID BALANCE. I ACKNOWLEDGE THAT I RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICE ACT.

_____
SIGNATURE DATE