EMERALD COAST FAMILY PHYSICIANS
4785 N. 9TH AVE
PENSACOLA, FL 32503

PATIENT INFORMATION: Date: _____

LAST NAME: _____ FIRST _____ MI _____

ADDRESS: _____

City/State/Zip: _____

HOME #: _____ CELL: _____

EMAIL ADDRESS: _____

PERFERRED METHOD OF CONTACT _____

SS #_____-_____-_____ DOB: _____ Sex: ☐ Female ☐ Male

PATIENT'S EMPLOYER: _____ WORK PHONE _____

PHARMACY NAME: _____ CITY: _____ PHONE: _____

SPOUSE INFORMATION:

NAME OF SPOUSE: _____ DOB: _____

SPOUSE'S EMPLOYER: _____ WORK PHONE: _____

IN CASE OF EMERGENCY WHOM WOULD YOU LIKE FOR US TO CONACT?

NAME: _____ RELATIONSHIP _____

PHONE NUMBER: _____

FROM TIME TO TIME, OUR DOCTORS OR STAFF MAY NEED TO REACH A PATIENT (OR THE PARENT'S OR GUARDIAN'S OF A PATIENT) DIRECTLY CONCERNING AN APPOINTMENT, TEST RESULTS, OR MEDICAL INFORMATION. IT IS AT THE PATIENT'S (OR PARENT'S OR GUARDIAN'S) DISCREATION WHEN AND WITH WHOM WE SHARE THIS INFORAMTION. THIS IS DUE TO HIPPA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996). I CONSENT FOR THIS PRACTICE TO USE OR DISCLOSE INFORMATION ABOUT THE PATIENT FOR THE PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS TO WHOMEVER I HAVE LISTED BELOW:

☐ MYSELF ONLY ☐ MY ANSWERING MACHINE ☐ THOSE LISTED BELOW

1. NAME: _____ RELATIONSHIP: _____ PHONE: _____
2. NAME: _____ RELATIONSHIP: _____ PHONE: _____
3. NAME: _____ RELATIONSHIP: _____ PHONE: _____

PATIENT SIGNATURE: _____ DATE: _____

STAFF MEMBER INT: _____

FINANCIAL AGREEMENT

Please remember that insurance is considered a method of reimbursing the patient for fees to the doctor and is NOT A SUBSTITUTE FOR PAYMENT. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

IN ORDER TO CONTROL YOUR OUTSTANDING BALANCE, IT IS OUR POLICY TO COLLECT CO-PAYS, CO-INSURANCE AND DEDUCTIBLE AT THE TIME OF SERVICE

INSURANCE INFORMATION:
PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Name of Insured: _____Patient Relationship to Insured_____

Insured Employer Name: _____

Insurance Company/Phone Number: _____ ( ) _____

Subscriber ID (Policy Number): _____ Group ID: _____

Effective Date: _____ Termination Date: _____ ☐ Female ☐ Male

Insured Date of Birth: _____ Insured's Social Security Number: _____

Insurance Company Address: _____

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Name of Insured: _____ Patient Relationship to Insured_____

Insured Employer Name: _____

Insurance Company/Phone Number: _____ ( ) _____

Subscriber ID (Policy Number): _____ Group ID: _____

Effective Date: _____ Termination Date: _____ ☐ Female ☐ Male

Insured Date of Birth: _____ Insured's Social Security Number_____

Insurance Company Address:_____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge. I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.

_____ _____

PATIENT'S/GUARDIAN'S SIGNATURE ***DATE***

STAFF MEMBER INT:_____