Patient Registration Information

*Please **PRINT** AND complete **ALL** sections below!*

PATIENT'S INFORMATION

Marital Status_____Single _____Married____ Divorced_____widowed_____ Sex: ____Male_____ Female

Ethnicity: ____Hispanic or Latino _____Non-Hispanic or Latino _____Decline

Race: ____American Indian or Alaska Native_____Native Hawaiian or other Pacific Islander___White____Asian___Black or African American____other___Decline

Name: _____Social Security: _____
Last Name, First Name, Initial

Date of Birth _____/_____/_____ Age _____ EMAIL Address: _____

Home Phone: ( ) _____ Work Phone ( ) _____ Cell Phone: ( ) _____

Address: _____ City: _____ State: _____ Zip: _____

Relationship to Patient: _____Self_____Spouse_____Child_____Other: _____ Name: _____

Please present Insurance cards to receptionist.

PAST MEDICAL RECORDS (Prior Primary Care Doctor)

Name: _____

Address: _____City: _____ State: __ Zip: ___

Phone: ( )_____ Fax: ( ) _____

EMERGENCY CONTACT

Name: _____Relationship:_____

Home Phone: ( ) _____ Work Phone: ( ) _____ Cell Phone: ( ) _____

Assignment of Benefits' Financial Agreement I hereby give lifetime authorization for payment of insurance benefits to be made directly to Park Avenue Medical, and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Date: _____ Signature: _____

Advanced Directives

All adults in healthcare settings in the state of Florida have the right to an "Advanced Directive". This is a written or oral statement made and witnessed in advance of a serious illness of injury, stating how medical decisions will be made. An advanced directive enables you to state your choice or name someone to make your choice for you, if you should become unable to make decisions about your medical treatment.

Do you have a living will? _____Yes _____ No

(If yes, please provide a copy to our office)