Rheumatology Associates Central Florida

3160 Southgate Commerce Blvd
Suite 30
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USA
(407) 859-4540

PATIENT INFORMATION

NAME (Last, First Middle)		MRN	SSN#	BIRTHDATE	LANGUAGE	SEX
LOCAL ADDRESS	CITY, STATE ZIP	REFERRING PHYSICIAN	SECONDARY/BILLING ADDRESS		ETHNICITY	
HOME PHONE	DAY PHONE	EMAIL ADDRESS	PRIMARY CARE PROVIDER	CITY, STATE ZIP	RACE	
MARITAL STATUS	STUDENT STATUS ☐ Full-Time ☐ Part-Time	SMOKER (Y/N)?	VETERAN (Y/N)?	EMERGENCY CONTACT NAME	CONTACT PHONE	HOME PHONE
SEXUAL ORIENTATION	PREFERRED PRONOUN	GENDER IDENTITY				

PRIMARY EMPLOYER	SECONDARY EMPLOYER (if Applicable)
ADDRESS	ADDRESS
CITY, STATE ZIP	CITY, STATE ZIP
WORK PHONE	WORK PHONE

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)		SSN#	BIRTHDATE	LANGUAGE	SEX
LOCAL ADDRESS	CITY, STATE ZIP		SECONDARY/BILLING ADDRESS (if Applicable)		
HOME PHONE	DAY PHONE	EMAIL ADDRESS	CITY, STATE ZIP		
MARITAL STATUS	STUDENT STATUS ☐ Full-time ☐ Part-time	SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER	HOME PHONE	
RELATIONSHIP TO PATIENT						

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY		POLICY#	
NAME OF INSURED		GROUP#	
ADDRESS OF INSURANCE COMPANY		COPAY AMT $	
CITY, STATE ZIP	PHONE	DEDUCTIBLE $	
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY			POLICY#
NAME OF INSURED	SSN#	BIRTHDATE	GROUP#
ADDRESS OF INSURANCE COMPANY			COPAY AMT $
CITY, STATE ZIP	PHONE		DEDUCTIBLE $
RELATIONSHIP TO PATIENT			EFFECTIVE DATE / EXPIRATION DATE

PATIENT RELEASE:

I Certified the information I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare), or purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider. I ACKNOWLEDGE THAT INTEREST OR A FEE, AT THE PROVIDERS CURRENT RATE MAY BE CHARGED on all balances owing to the provider that are past due. I permit a copy of this release to be used in place of the original.

SIGNATURE OF PATIENT/GUARDIAN _____ DATE _____