



Name: _____ Email Address: _____

Social Security #: _____ Sex: M or F D.O.B: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Leave Message at Home: Yes or No (call order _____)

Cell Phone: _____ Leave Message on Cell: Yes or No (call order _____)

Employment Status (circle one): FT / PT / Retired / Other Student Status (circle one): FT / PT

Employer: _____

Work Phone/ext: _____ Leave Message at Work: Yes or No (call order _____)

Marital Status: Married Single Divorced Widowed Legally Separated Significant Other

Name of Spouse: _____ Home Phone: _____ Work: _____

Emergency Contact: _____

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

Phone: _____ Relationship: _____

Primary Insurance: _____ Insured's Name: _____

Social Security #: _____ D.O.B: _____ Relationship: _____

Policy / Subscriber ID: _____ Group #: _____

Eligibility / Customer Service Phone: _____

Secondary Insurance: _____ Insured's Name: _____

Secondary ID #: _____ Group #: _____

Preferred Pharmacy: _____

Pharmacy Address: _____ **Pharmacy Phone:** _____

Insurance Assignment & Release Form: I hereby authorize my Insurance Benefits to be paid directly to Lake Mary Family Physicians P.A.. I also authorize the physician to release any information required and/or requested by my insurance carrier.

Signature: _____ **Date:** _____

Co-Pay or Payment is due upon the day services are rendered. Cash, Check, Visa, MasterCard or Discover accepted.