Patient Information Sheet

First Care Medical Centers, P.A. 12995 S. Cleveland Ave., Ste. 184, Fort Myers, FL 33907

Last Name: _____ First Name: _____ MI: _____

DOB: _____ Sex: Male _____ Female_____ S.S. #: _____

Local Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____) _____ Cell #: (_____) _____

Employer Name: _____ Employer Address: _____

City: _____ State: _____ Zip: _____ Work #: _____

Marital Status: _____ Spouses Name: _____

Medical information May Be Disclosed To: _____

Test results may be left on answering machine: (circle one) Yes No

Emergency Contact: _____ Relationship: _____

Emergency #: (_____) _____

Northern Address: _____ City: _____

State: _____ Zip Code: _____ Home #: (_____) _____

Referred by: (circle one) Friend Doctor Employer Sign Direct Mail
Referral Service internet Other: _____

Advance Directives: (circle any that apply) Living Will DNR Health Care Surrogate

Insurance Information:

Name of Insurance Company: _____ Effective Date: _____

Name of Supplement (for Medicare): _____ Effective Date: _____

I understand my signature authorizes payment to be made and authorizes release of medical information necessary to pay a claim. Once the HCFA-1500 claim form is completed, my signature below authorizes releasing of the information to the insurer of agency shown. In Medicare assigned cases, the physician of supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible for the deductible, co-insurance, and non-covered services. I hereby consent to the examination, treatment, payment, and procedures, which may be performed during this, and subsequent visits, including emergency treatment deemed necessary by First Care Medical Centers, P.A. staff. I authorize payment directly to First Care of my insurance benefits herein specified, and otherwise payable to me, but not to exceed the arrangements for payment may result in my account being placed with a collection agency, and I will be charged interest, collection fees, and/or attorney fees.

Patient/Guardian Signature: _____ Date: _____