Name _____ D**ate**_____ **Marital Status**_____

Social Security #_____ **Home Phone**_____ **Birthdate**_____

Home Address_____

City _____ **State**_____ **Zip**_____ **Sex**: M or F

Employer_____ **Occupation**_____

Work Address and ph#_____

Cell Phone_____ **Emergency Contact and ph#**_____

E-mail Address_____

Local Preferred Pharmacy Name and Location_____

Insurance Company_____ **Insured/Primary Social Sec #**_____

Insured Name_____ **Insured Birthdate**_____

Insurance ID #_____ **Group#**_____

If the patient is Married or is a Minor, Please complete the information on your spouse or the responsible party for the child.

Name_____ **Relation**_____

Address_____

Employer and Address_____ **Business Phone/Ext**_____

Patient Acknowledgment: I understand I have the right to accept and refuse medical treatment and to exercise my right and implement an Advance Directive. "Advance Directive" refers to any legal document that informs family members and medical personnel how you wish to be treated if you are hospitalized and cannot communicate your wishes. Please check the following statements that apply:

- ☐ **I Have Not executed an Advance Directive**
- ☐ **I Have executed an Advance Directive** Location of Form_____
  - ☐ Living Will
  - ☐ Durable Power of Attorney
  - ☐ Do Not Resuscitate (DNR) Order
  - ☐ Designation of health care surrogate form Designee/Guardian_____

Signature_____ **Witness:** _____ **Date**_____

Insurance Assignment & Release Form: I Hereby authorize my Insurance Benefits to be paid directly to Oviedo Family Health Center, P.A. I also authorize the physician to release any information required and/or requested by my insurance carrier.

Office Policy: I understand that I am responsible for insurance deductibles, co-pays and percentages as per my insurance policy. I understand all fees are due at the time services are rendered. I understand that there is a $15 charge on all returned checks and a $25 charge for confirmed appointments cancelled without 24 hours prior notice or failure to show up for a scheduled and confirmed appointment. **I also understand that Oviedo Family Health Center files claims to the insurance company as a courtesy, and that I am responsible for any services the insurance company does not pay for.**

Signature_____ **Date**_____