Florida Primary Care & Sports Medicine
140 Pinnacles Drive
Palm Coast, FL 32164
Phone (386) 313-6035
Fax (386) 313-6078

Patient Registration Information

Social Security Number: _____-_____-_____ Today's Date: _____ /_____ /_____

Name: First _____ Middle _____ Last_____

Sex: □Male □Female Date of Birth: _____ /_____ /_____

Marital Status: □Married □Single □Divorced □Widowed **Email address:** _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Phone: Home ( ) _____Cell ( ) _____ Work ( ) _____

Preferred method for Appointment Reminder's - □ Text □ Email □ Call □ Do not contact me for reminder's

Check one: Employed □ Employer _____ □Retired □Student □Other _____

Primary Insurance Information

Insurance Company: _____ Name of Policy Holder _____

Date of Birth of Policy Holder: _____ /_____/ _____ Policy Holders SSN: _____-_____-_____

Relationship to Policy Holder: □Child □Wife □Husband □Other_____

Insurance Number: _____ Group: _____

Emergency Contact Information (Required)

Relationship to Patient: _____ Phone Number: _____

Name: First _____ Middle _____ Last_____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Please Read and Sign

- I certify that the above information is true and correct to the best of my knowledge.
- I authorize the release of any medical information necessary to process this claim and also request payment of insurance benefits either to myself or to the party who accepts assignments.
- I authorize release of medical payment to Florida Primary Care and Sports Medicine.
- I understand that should my account fall into arrears and be sent off to a collection agency or credit bureau, I will be responsible for any fees incurred.
- I understand that if my insurance company does not cover all of the professional service charges incurred, that I am responsible for any balance above insurance payment.
- Consent for treatment: I hereby consent the Provider to render medical evaluation treatment and the performance of diagnostic testing and procedures according to the Provider's discretion. **No guarantees will be made as to the results of examinations and or treatments.**
- I understand Florida Primary Care and Sports Medicine may occasionally send a text and or email review of services.

Signature: _____ **Date**: _____