

PLEASE FILL OUT COMPLETELY. THIS INFORMATION IS ESSENTIAL TO OUR OFFICE AND YOURSELF.

MEDICAL DIAGNOSTICS ASSOCIATES, P.A.

Patient Information (Please Print Clearly)

Name: _____ M ___ F ___ Marital Status _____

Address: _____ Cell Phone () _____

Town _____ State _____ Zip _____ Home Phone () _____

Date of Birth: _____ Social Security Number _____

Employer Name & Address _____

Employer Phone Number _____ Occupation _____

Spouse's Name: _____ Social Security # _____ DOB _____

Spouse's Employer Name/Phone # _____

INSURANCE INFORMATION

Primary _____ Policy # _____ Group# _____

Subscriber's Name: _____ Relationship to Subscriber _____

Secondary Insurance _____ Policy # _____ Group # _____

Subscriber's Name _____ Relationship to Subscriber _____

CORRECT AND COMPLETE INSURANCE INFORMATION IS ESSENTIAL TO AVOID DELAY/DENIAL

Referring Physician's Name and Address _____ **Primary Care Physician's Name and Address** _____

Phone # _____ Phone # _____

Emergency Contact Name and Phone# _____

Name/Address/Phone # of nearest relative not living with you. _____

PHARMACY NAME & PHONE NUMBER _____

INSURANCE RELEASE – I hereby authorize Medical Diagnostics Associates, P.A. to release information acquired in the course of medical examination or treatment to my insurance carrier and to file my health insurance claims for services rendered.

Signature _____ Date _____

MEDICARE PATIENTS ONLY – I hereby authorize direct payment to Medical Diagnostics Assoc.,P.A. for services billed on assigned basis.

Signature _____ Date _____