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(407) 352- 9717 PHONE (407) 354-5425 FAX

NEW PATIENT PACKET

PATIENT INFORMATION – PLEASE PRINT			
NAME (Last, First, Middle)		BIRTHDATE (MM/DD/YYYY) / /	SSN
LOCAL ADDRESS		CITY, STATE, ZIP	
RACE:	LANGUAGE:	EHNICITY <input type="checkbox"/> HISPANIC <input type="checkbox"/> NON-HISPANIC <input type="checkbox"/> OTHER	PHARMACY NAME: PHONE: () -
EMPLOYER'S NAME / EMPLOYER'S ADDRESS / OCCUPATION			REFERRED BY:
<i>I allow Southwest Orlando Family Medicine to CALL OR TEXT me on the specified number(s).</i>			
HOME PHONE () -		CELL PHONE () -	WORK PHONE () -
<i>Email Address: _____@_____.com</i>			
<input type="checkbox"/> YES <i>I allow Southwest Orlando Family Medicine to EMAIL me through eClinicalWorks Patient Portal.</i> <input type="checkbox"/> NO <i>I do not allow Southwest Orlando Family Medicine to EMAIL me through eClinicalWorks Patient Portal.</i>			
 <i>Southwest Orlando Family Medicine encourages the use of the patient portal as we go green by minimizing the printing of paper. The patient portal is a secured system operated by a password-protected login and allows patients on-line access to their medical records.</i>			
ASSIGNMENT OF BENEFITS			
<p>It is therefore my sole responsibility as the patient to know my insurance company coverage, including which laboratory, medical provider or facilities my insurance company is contracted with. I will not hold Southwest Orlando Family Medicine and its management responsible for any bills incurred regarding any expenses or errors pertaining to me going to a non-covered laboratory, medical provider or facilities.</p> <p>A photocopy of the Assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.</p> <p>I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.</p>			
Ins. Card holder (if not patient): _____ DOB: _____ SSN _____ Relationship _____			

By signing, I hereby acknowledge that all the information provided above is accurate and true. I have also read and understood the **Notice of Privacy Practice, Patient Policies** and **Financial Policies**, which states that I am fully responsible for any services, balances, and/or no-show fees incurred.



PATIENT / RESPONSIBLE PARTY (SIGNATURE)

_____/_____/_____
DATE