Patient Information (PLEASE PRINT)

Date	Social Security #	Birthdate	
Name (Last Name) (First Name) (Middle Initial)		Sex ❑ M ❑ F ❑ Transgender	Age
Address (City)		(State) (Zip)	

Home Phone	Cell Phone	Email

❑ Married ❑ Separated ❑ Widowed ❑ Divorced ❑ Single ❑ Partnered

Race	Ethnicity:	Preferred Language	Preferred method of contact *(check all that appy)*
❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ Hispanic ❑ Native Hawaiian ❑ White ❑ Other Pacific Islander ❑ Other	❑ Hispanic ❑ Non-Hispanic		❑ Home Phone ❑ Cell Phone/SMS (text) ❑ Work Phone ❑ Email ❑ Patient portal

Patient Employer/School	Occupation
Employer/School Address	Employer/School Phone
In case of emergency who should be notified?	Phone
Name of Primary Care Physician	Name of Referring Physician *(if different from Primary Dr.)*

Primary Insurance *(If this is not filled out you will be billed for all visits)*

Insurance Company		
Subscriber #	Group #	
Person Responsible for Account (Last Name)	(First Name)	(Middle Initial)
Relationship to Patient	Birthdate	Soc. Sec. #
Address if different from patient (City)	(State) (Zip)	Phone
Person Responsible Employed by	Occupation	
Business Address (City)	(State) (Zip)	Business Phone
Names of other dependents covered under this plan		Copay

Additional Insurance *(Is patient covered by additional Insurance? ■ Yes ■ No)*

Insurance Company		Soc. Sec. #
Subscriber #	Group #	
Subscriber Name	Relationship to Patient	Birthdate
Address if different from patient (City)	(State) (Zip)	Phone
Subscriber Employed by		Business Phone
Names of other dependents covered under this plan		Copay

Assignment and Release

I certify that I and my dependents have insurance coverage with ______________________________ and assign
Name of Insurance Company
directly to Center for Rheumatic Diseases and Osteoporosis, P.A. all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance admissions.
The Center for Rheumatic Diseases and Osteoporosis, P.A. may use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent includes my authorization to release medical information to my primary care physician and/or consulting physicians to assist with continuity of my health care. This release will remain in effect until I cancel this release in writing.

______________________________ Signature of Patient, Parent, Guardian or Personal Representative

______________________________ Date

______________________________ Please print name of Patient, Parent, Guardian or Personal Representative

______________________________ Relationship to Patient