



New Patient Registration

Please have all **INSURANCE CARDS** and **DRIVER'S LICENSE** or **PHOTO ID** ready to copy.
(PLEASE PRINT)

Today's Date: _____ Account #: _____

LAST NAME		FIRST		MI	SEX MALE FEMALE	MARRIED DIVORCED	SINGLE WIDOWED
SOCIAL SECURITY NO. - -		DATE OF BIRTH / /		RACE		EMPLOYED STUDENT	RETIRED
LOCAL ADDRESS			CITY		STATE	ZIP CODE	
HOME PHONE		WORK PHONE		CELLULAR PHONE			
EMAIL ADDRESS			LANGUAGE PREFERENCE <input type="checkbox"/> ENGLISH <input type="checkbox"/> SPANISH <input type="checkbox"/> OTHER _____ <input type="checkbox"/> HEARING IMPAIRED <input type="checkbox"/> VISION IMPAIRED				
PERMANENT ADDRESS			CITY		STATE	ZIP CODE	

IN CASE OF EMERGENCY, CONTACT:

LAST NAME		FIRST					
ADDRESS			CITY		STATE	ZIP CODE	
HOME PHONE		WORK PHONE		CELL PHONE		RELATIONSHIP	

IS THE PATIENT THE FINANCIALLY RESPONSIBLE PARTY? YES NO IF NO, PLEASE COMPLETE THIS SECTION

RELATIONSHIP		SEX M F		DAYTIME PHONE			
FIRST NAME		MIDDLE		LAST NAME			
ADDRESS			CITY		STATE	ZIP CODE	

EMPLOYER

EMPLOYER	ADDRESS	CITY	STATE	ZIP CODE
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INSURANCE INFORMATION PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST

INSURANCE COMPANY		INSURED'S DOB	
INSURANCE/CARD HOLDER'S NAME		RELATIONSHIP	
ID #	GROUP #	PHONE	

SECONDARY INSURANCE COMPANY INFORMATION

INSURANCE COMPANY NAME		INSURED'S DOB	
INSURANCE/CARDHOLDER'S NAME		RELATIONSHIP	
ID#	GROUP #	PHONE	

IS THE REASON FOR TODAY'S VISIT THE RESULT OF AN ACCIDENT? YES NO IF YES, PLEASE COMPLETE THIS SECTION

PLEASE CHECK WHICH TYPE OF ACCIDENT: WORKERS' COMPENSATION AUTOMOBILE OTHER			
DATE OF ACCIDENT		PLACE OF ACCIDENT	HOW DID ACCIDENT HAPPEN?
CLAIM #	CLAIM REPRESENTATIVE/ADJUSTER		

IF AT WORK INJURY, PLEASE COMPLETE THIS SECTION

EMPLOYER NAME		EMPLOYER PHONE	
ADDRESS	CITY	STATE	ZIP

HOW DID YOU HEAR ABOUT OUR MEDICAL FACILITY?

FRIEND	TELEPHONE BOOK	DRIVE BY	NEWSPAPER	REFERRAL BY: _____	PRIMARY PHYSICIAN _____
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Please Read and Sign Back

Date Scanned: _____ Initials: _____

Account Number: _____

1. **CONSENT FOR TREATMENT.** I understand that medical treatment of an immediate nature may be necessary for the patient and that such medical care, treatment, and procedures will be performed by licensed physicians and/or employees of S.M.S., D.O., P.A., d/b/a GULF COAST MEDICAL CENTER during posted operating hours. I understand that medical treatment only is being provided and I hereby grant my authorization and consent to such treatment and procedures, and certify that no guarantee or assurance has been made as to the results, that may be obtained. I understand and recognize that GULF COAST MEDICAL CENTER is a teaching facility.

Do you have Advance Directives? Yes No

2. **FINANCIAL RESPONSIBILITY.** For and in consideration of the care and treatment provided to the patient, I promise to pay S.M.S., D.O., P.A., d/b/a GULF COAST MEDICAL CENTER all charges for services rendered to or on behalf of the patient. Any services that are not covered by insurance are the patients' responsibility and will be due and payable at the time services are rendered unless other arrangements are made in advance.

3. **RELEASE OF MEDICAL INFORMATION.** I hereby authorize S.M.S., D.O., P.A., d/b/a GULF COAST MEDICAL CENTER to release any medical information, in connection with these services, requested with regard to processing my claim or to my personal physician, insurance carrier, and/or attorney of record with appropriate release.

4. **DIAGNOSTIC TESTING.** Please be aware of YOUR insurance policy exclusions with regard to diagnostic testing. Although GULF COAST MEDICAL CENTER strives to provide our patients with any type of diagnostic testing he/she may need, certain insurance companies have specific facilities you must go to for certain tests, i.e., laboratory, x-ray procedures. It is your responsibility to verify that procedures performed at GULF COAST MEDICAL CENTER are covered by your insurance policy. The patient is ultimately held responsible for any balance due to the reason stated above.

5. **MEDICARE/MEDIGAP, BLUE CROSS/BLUE SHIELD OR OTHER HEALTH INSURANCES.** I hereby authorize S.M.S., D.O., P.A., d/b/a GULF COAST MEDICAL CENTER to apply for Medicare/Medigap, and other health insurance benefits on my behalf. I hereby request reimbursements from any applicable insurance to be made directly to S.M.S., D.O., P.A., d/b/a GULF COAST MEDICAL CENTER. I certify that the information I have provided with regard to my insurance carrier is correct. I authorize the release of medical information about me to my health insurance carrier and HCFA (Health Care and Finance Administration) agents, as well as any and all other information needed to determine the benefits payable for related service(s). I hereby authorize payment of Medigap benefits be made on my behalf to S.M.S., D.O., P.A., d/b/a GULF COAST MEDICAL CENTER. I release any holder of Medicare information about me to my insurance carriers, necessary to determine benefits payable for related services.

6. **ATTORNEY OF RECORD:** I authorize my attorney to release to S.M.S., D.O., P.A., d/b/a GULF COAST MEDICAL CENTER any information detailing my case, case status, or case settlement in connection with date of accident _____ and medical services rendered.

7. The policy of this facility is to call 911 for all emergencies within the medical center.

THE UNDERSIGNED HEREBY MAKES THE FOLLOWING ACKNOWLEDGEMENTS AND AGREEMENTS REGARDING THE MEDICAL TREATMENT TO BE PROVIDED BY S.M.S., D.O., P.A., d/b/a GULF COAST MEDICAL CENTER, S.M.S. IMAGING, d/b/a FLORIDA INSTITUTE FOR ADVANCED DIAGNOSTIC IMAGING, GULF COAST MEDICAL CENTER PHYSICAL THERAPY, INC. AND ANY OF ITS DULY AUTHORIZED AGENTS TO THE PATIENT WHOSE NAME APPEARS ON THIS FORM.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE ACKNOWLEDGEMENTS AND AGREEMENTS. I ALSO UNDERSTAND THAT IT IS A CRIME TO FILL OUT THIS FORM WITH FACTS I KNOW ARE FALSE OR TO LEAVE OUT FACTS I KNOW ARE IMPORTANT.	
_____	_____
Signature of Patient/Guardian	Date
_____	_____
Witness	Account Number

BROCHURE GIVEN NOTICE OF PRIVACY PRACTICES POLICY SIGNED Date Scanned: _____ Initials: _____