

Lisa F. Minton, MD
NEW PATIENT INFORMATION

Patient's Last Name _____ First _____ Middle Initial _____

Patient's Social Security Number ____ - ____ - _____ Date of Birth _____ Age ____ Male Female

Address _____ Apt # _____

City _____ State _____ Zip Code _____

Telephone # Home _____ Cell # _____

Work _____ Email _____

Do you have an alternate address? Yes No If yes _____

Marital Status Single Married Divorced Widowed Separated

Employment Status Full-time Part-time Retired Other _____

Employer _____

Employer Address _____

Student Full-time Part-time School name & Address _____

Spouses/Parent Name: Last _____ First _____

Social Security Number: ____ - ____ - _____ Birth date _____ age _____

Employer _____ Phone # _____

Employer Address _____

Insured: SELF SPOUSE PARENT

Other: Last Name: _____ First Name _____

Name of closest relative not living with you _____

Relationship _____ Phone # _____

Who can we thank for referring you to our practice?: Friend Family Advertisement : _____

Name: _____ Other: _____

Referring Physician: _____ Phone # _____

Address _____

**PLEASE HAVE YOUR INSURANCE CARD AND PHOTO ID READY FOR THE RECEPTIONIST.
PAYMENT FOR PROFESSIONAL SERVICES IS DUE WHEN SERVICE IS RENDERED.**

Date: _____

CONSENT FOR EVALUATION OR TREATMENT

The undersigned hereby consents to whatever evaluation or treatment the assigned healthcare provider may deem necessary to the patient named above.

PATIENT, PARENT, LEGAL GUARDIAN OR AUTHORIZED REPRESENTATIVE _____
DATE

INSURANCE ASSIGNMENT

I hereby authorize my insurance benefits to be paid directly to Florida Physicians Medical Group. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered.

PATIENT SIGNATURE _____
DATE

**FOR MEDICARE PATIENTS ONLY
MEDICARE PART B SIGNATURE AUTHORIZATION – LIFETIME**

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare Claim. I permit a copy of this authorization to be used in place of the original. I request that payment of the authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the service or authorize such physician or organization to submit a claim to Medicare for payment to me.

PATIENT SIGNATURE _____
PATIENT NAME

MEDICARE B # _____
DATE

ADVANCE DIRECTIVE

I understand that the terms of any Advance Directive that I have executed will be followed by the health care facility and my care givers to the extent permitted by law. Please check one of the following statements:

() I HAVE executed an Advance Directive.
(Living Will, Durable Power of Attorney, Designation of a Health Care Surrogate.)

Please provide copies of Advance Directive/Living Will to the receptionist to be included in your medical record.

() I HAVE NOT executed an Advance Directive
(Living Will, Durable Power of Attorney, Designation of a Health Care Surrogate.)

PATIENT SIGNATURE _____
DATE