Date:_____ Home Phone:_____

Patient:_____
Last Name First Name Initial Jr/Sr

Responsible Party (if a minor)_____

Street Address:_____Mailing:_____

City:_____State:_____Zip:_____

Sex ☐ M ☐ F Birthdate_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed By _____

Business Address: _____

Occupation: _____ Business Phone:_____

Spouse (or responsible party) Name:_____ Birthdate:_____

Business Address: _____

Occupation: _____ Business Phone:_____

Who is responsible for this account?_____ Relationship to Patient _____

Social Security #_____ Spouse's Social Security # _____

List other Family Members in Household: Total Family Members in Household: _____

1

Last Name First Name Initial Jr/Sr

Date of Birth Social Security # Gender Relationship

2

Last Name First Name Initial Jr/Sr

Date of Birth Social Security # Gender Relationship

3

Last Name First Name Initial Jr/Sr

Date of Birth Social Security # Gender Relationship

4

Last Name	First Name	Initial	Jr/Sr

Date of Birth	Social Security #	Gender	Relationship

5

Last Name	First Name	Initial	Jr/Sr

Date of Birth	Social Security #	Gender	Relationship

6

Last Name	First Name	Initial	Jr/Sr

Date of Birth	Social Security #	Gender	Relationship

7

Last Name	First Name	Initial	Jr/Sr

Date of Birth	Social Security #	Gender	Relationship

8

Last Name	First Name	Initial	Jr/Sr

Date of Birth	Social Security #	Gender	Relationship

9

Last Name	First Name	Initial	Jr/Sr

Date of Birth	Social Security #	Gender	Relationship

10

Last Name	First Name	Initial	Jr/Sr

Date of Birth	Social Security #	Gender	Relationship

Patient Name: _____

Do you have Medicaid? ☐ No ☐ Yes Do you have Medicare? ☐ No ☐ Yes

Do you have Medical Insurance? ☐ No ☐ Yes

If yes, Name of Primary Insurance
_____

Contract #_____ Group # _____ Subscriber #_____

Name of Secondary Insurer (If any) _____

Contract #_____ Group # _____ Subscriber #_____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____
Name of Insurance Company

and assign directly to Hardee County Health Department all medical 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____
Signature of Insured/Guardian Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Hardee County Health Department for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____
Beneficiary Signature Date