



**LONGWOOD
FAMILY
MEDICINE**

515 W. State Road 434 Suite 301
Longwood, Florida 32750
407-786-0004 • Fax 407-786-0016

Date ____/____/____

Patient Information

Last Name _____ First _____ M.I. _____ Sex _____

Address _____ Apt# _____ City _____ St. _____ Zip _____

Home Phone _____ Work/Cell Phone _____ Driver's License# _____ St. _____

Age _____ Date of Birth ____/____/____ Marital Status: Married _____ Divorced _____ Single _____ Widowed _____

Occupation _____ Employer _____ Address _____

Guardian/Spouse _____ Relationship _____ Date of Birth ____/____/____

Emergency Contact _____ Relationship _____ Phone _____

Referred by _____ Name of Last Physician _____

Address _____ City _____ St. _____ Zip _____

Insurance Information

Primary Insurance _____ Address _____

Phone # _____ Policy # _____ Group/Name _____

Subscriber Name _____ Date of Birth ____/____/____ Relationship _____

Secondary Insurance _____ Address _____

Phone # _____ Policy # _____ Group/Name _____

Subscriber Name _____ Date of Birth ____/____/____ Relationship _____

Medical Release Authorization

I authorize the release of any payment and medical information necessary to process claims on my behalf.

MEDICAL RELEASE AUTHORIZATION

Insured party must sign for all claims. Dependent patient must also sign if not a minor. I authorize any insurance company, employer, hospital, physician, dentist, or pharmacist to release any information requested with regard to processing my claims. I certify that the information I furnish is true and correct. I know it is a crime to fill out this form with information I know is false or to leave out information I know is important.

Insured/Responsible Party Signature _____ Date ____/____/____

Dependent Patient Signature in not a minor _____ Date ____/____/____