



825 OAKLEY SEAVER DRIVE | CLERMONT, FL 34711 | TEL: 352-536-1764 | FAX: 352-536-1765

TODAY'S DATE: _____

NAME: _____ BIRTH DATE: _____

SOCIAL SECURITY #: _____ MARITAL STATUS: _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

WORK PHONE/EXT: _____ EMAIL ADDRESS: _____

SEX (CIRCLE ONE): MALE / FEMALE / OTHER ETHNICITY (CIRCLE ONE): NON HISPANIC • HISPANIC • DECLINE TO ANSWER

RACE(CIRCLE ONE): WHITE • BLACK • ASIAN • NATIVE AMERICAN • HISPANIC • PACIFIC ISLANDER • OTHER _____

EMPLOYMENT STATUS (CIRCLE ONE): FT / PT / RETIRED / OTHER: _____ STUDENT STATUS (CIRCLE ONE): FT / PT

EMPLOYER: _____ OCCUPATION: _____

PRIMARY INSURANCE: _____ (CIRCLE ONE): HMO / PPO / OTHER

INSURANCE ID #: _____ GROUP #: _____ EFFECTIVE DATE: _____

IF YOU ARE NOT THE PRIMARY INSURED THEN PLEASE COMPLETE THE FOLLOWING:

PRIMARY INSURED'S/RESPONSIBLE PARTY NAME: _____ BIRTH DATE: _____

PRIMARY SOCIAL SECURITY #: _____ SEX (CIRCLE ONE): MALE / FEMALE

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ RELATIONSHIP: _____

SECONDARY INSURANCE: _____ INSURED'S NAME: _____

SECONDARY ID #: _____ GROUP #: _____

NAME OF SPOUSE/ PARENT/PARTNER: _____ HOME PHONE: _____ WORK: _____

EMERGENCY CONTACT:(IF DIFFERENT FROM ABOVE) _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ RELATIONSHIP: _____

PATIENT ACKNOWLEDGMENT: I understand I have the right to accept and refuse medical treatment and to exercise my right and implement an Advance Directive. "Advance Directive" refers to any legal document that informs family members and medical personnel how you wish to be treated if you are hospitalized and cannot communicate your wishes. Please check the following statements that apply:

☐ I Have Not executed an Advance Directive

☐ I Have executed an Advance Directive

Location of Form: _____

☐ Living Will

☐ Durable Power of Attorney

☐ Do Not Resuscitate (DNR) Order

☐ Designation of health care surrogate form Designee/Guardian: _____

SIGNATURE: _____ WITNESS: _____ DATE: _____

INSURANCE ASSIGNMENT & RELEASE FORM: I hereby authorize my Insurance Benefits to be paid directly to Physicians Medical Group, LLC. I also authorize the physician to release any information required and/or requested by my insurance carrier.

SIGNATURE: _____ DATE: _____