The Rice Diet of Central Florida

PATIENT INFORMATION FOR MEDIAL RECORDS (PLEASE PRINT)

Patient's Full Legal Name _____ SS# _____
Address _____ City/State _____ Zip _____
Home Phone _____ Cell # _____ Date of Birth _____ Sex: ☐ Male ☐ Female
Employed by _____ Work # _____
Work Address _____ Occupation _____
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow/Widower

Spouse's Full Legal Name _____ Spouse's SS# _____
Spouse's Date of Birth _____ Spouse Employed by _____
Spouse's Work # _____ Spouse's Occupation _____
Spouse's Work Address _____
Spouse's Home Phone _____ Cell # _____
If patient is a minor, who is responsible for bill? _____ Relationship _____
Address of responsible party _____ City/State _____
Zip _____ Home Phone _____ Work # _____

NAME OF PARENT, NEAREST RELATIVE, OR FRIEND TO CONTACT IN EMERGENCY

Name _____ Relationship _____ Phone #_____

HOW DO YOU INTEND TO PAY? ☐ CASH ☐ CHECK ☐ VISA/MC/AMEX

INSURANCE INFORAMTION

DO YOU HAVE MEDICARE? ☐ YES ☐ NO Medicare # _____

First Insurance Company: _____
Address _____ City, State, Zip _____
Policy # _____ Group # _____
Insured's Name _____ Insured's Relationship to Patient _____
Insured's Date of Birth _____ Insured's SS# _____

Second Insurance Company: _____
Address _____ City, State, Zip _____
Policy # _____ Group # _____
Insured's Name _____ Insured's Relationship to Patient _____
Insured's Date of Birth _____ Insured's SS# _____

REFERRED BY _____

Date _____ Signature _____