

FLORIDA JOINT AND SPINE INSTITUTE, P.A.

PLEASE PRINT CLEARLY

PATIENT INFORMATION

I AM GIVING MY AUTHORIZATION
TO RELEASE MEDICAL RECORDS
TO BE PICKED UP BY:

LAST NAME _____

FIRST NAME _____

____ SELF ONLY

LOCAL MAILING
ADDRESS _____

____ SPOUSE; _____

CITY _____

____ PARENT; _____

STATE _____ ZIP _____

____ CHILD; _____

TELEPHONE (HOME) _____

____ ATTORNEY; _____

TELEPHONE (CELL) _____

MEDICAL RECORDS MAY INCLUDE:
XRAYs, MRI DISCS, OFFICE NOTES,
LAB REPORTS, PRESCRIPTIONS,
& OPERATION NOTES.

PRIMARY
INSURANCE: _____

SECONDARY INSURANCE: _____

OTHER
ADDRESS _____

CITY _____

STATE _____ ZIP _____

TELEPHONE _____

SEX _____ MALE _____ FEMALE

ACCIDENT DATE: _____

BIRTHDATE ____/____/____

REFERRED BY: _____

SOCIAL SECURITY# _____

____ SINGLE _____ MARRIED _____ DIVORCED _____ WIDOWED

IF PATIENT IS A MINOR
PARENT _____ ADDRESS _____

SOCIAL SECURITY# _____ TELEPHONE _____

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND REQUEST PAYMENT OF MEDICARE/CHAMPUS BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT. I AUTHORIZE MEDICARE CROSSOVER SECONDARY INSURANCE PAYMENTS TO THE PROVIDER WHO ACCEPTS ASSIGNMENT (MEDIGAP). I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE NAMED DOCTOR OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF TREATMENT, AND AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.

BY MY SIGNATURE I ACKNOWLEDGE THE ABOVE STATEMENTS AND AUTHORIZE SAME.

PATIENT SIGNATURE _____ DATE _____