INSURANCE INFORMATION

(PLEASE PROVIDE ALL INSURANCE CARDS FOR COPYING)

SUBSCRIBER NAME: _____ SUBSCRIBERS DOB: _____

SUBSCRIBERS SS#: _____ RELATIONSHIP: _____

INSURANCE COMPANY: _____

CLAIM ADDRESS: _____

INSURANCE IN #: _____

DEDUCTIBLE AMOUNT: _____ AMOUNT OF CO-PAY (IF ANY)?: _____

DO YOU HAVE ADDITIONAL INSURANCE? ❑ YES ❑ NO

(IF YES, COMPLETE THE FOLLOWING:)

SUBSCRIBER NAME: _____ SUBSCRIBERS DOB: _____

SUBSCRIBERS SS#: _____ RELATIONSHIP: _____

INSURANCE COMPANY: _____

CLAIM ADDRESS: _____

INSURANCE IN #: _____

DEDUCTIBLE AMOUNT: _____ AMOUNT OF CO-PAY (IF ANY)?: _____

ASSIGNMENT OF BENEFITS / AUTHORIZATION FOR TREATMENT

I hereby authorize treatment and authorize the provider of medical services to release any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I further authorize payment of insurance benefits otherwise payable to me directly to the provider of services. A copy of this signature is as valid as the original. I understand that I am financially responsible for all charges not covered by my insurance.

X_____ _____

SIGNATURE OF PATIENT OR PARENT IF MINOR DATE

MEDICARE PATIENTS: SIGNATURE ON FILE

I request payment of authorized Medicare benefits be made either to me or on my behalf to Thomas E. Carson, M.D., P.A., for any services furnished me by the listed provider/supplier. 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 provider 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 noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare Carrier.

X_____ _____

SIGNATURE OF PATIENT OR PARENT IF MINOR DATE

REFERRAL INFORMATION

WHO MAY WE THANK FOR REFERRING YOU? _____

CARSON FAMILY CARE CENTER
1259 S. Pinellas Avenue
Tarpon Springs, FL 34689-3719
(727) 938-1908

PATIENT REGISTRATION

Thank you for choosing our office! In order to serve you properly, we need the following information.
(Please print. All information will be confidential.)

DATE: _____ PATIENT NAME: _____

SS# _____ DATE OF BIRTH: _____ SEX: M F

MARITAL STATUS: (CHECK ONE) ❑ S ❑ M ❑ W ❑ SEP ❑ D

FL DRIVERS LICENSE #: _____ OCCUPATION: _____

EDUCATION LEVEL: ❑ HIGH SCHOOL ❑ COLLEGE ❑ GRADUATE DEGREE

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

MAILING ADDRESS (IF DIFFERENT): _____

CITY: _____ STATE: _____ ZIP: _____

PATIENT EMPLOYER INFORMATION

EMPLOYERS NAME: _____ EMPLOYERS PHONE: _____

EMPLOYERS ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

SPOUSE INFORMATION

SPOUSES NAME: _____ SPOUSES EMPLOYER: _____

SPOUSES EMPLOYERS ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

SPOUSES EMPLOYERS PHONE: _____

CONSENT TO SPEAK TO OTHER RESPONSIBLE PERSON / SPOUSE CONCERNING FINANCIAL DATA: ❑ YES ❑ NO

EMERGENCY CONTACT

NEAREST FRIEND / RELATIVE (NOT LIVING WITH YOU):

NAME: _____ PHONE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

MEDICAL RECORDS

DO YOU HAVE MEDICAL RECORDS FROM A PREVIOUS PHYSICIAN THAT YOU WOULD LIKE TO TRANSFER HERE? ❑ YES ❑ NO

IF YES, WOULD YOU LIKE A MEDICAL RELEASE FORM? ❑ YES ❑ NO

ADVANCED DIRECTIVES / LIVING WILL

DO YOU HAVE ADVANCED DIRECTIVES? ❑ YES ❑ NO

IF YES, PLEASE BRING A COPY FOR YOUR CHART.

IF NO, ARE YOU INTERESTED IN INFORMATION ABOUT ADVANCED DIRECTIVES? ❑ YES ❑ NO