FLORIDA EAST COAST MEDICAL GROUP

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NEW PATIENT INFORMATION

(Please Print)

PATIENT NAME: _____ DATE: _____

DATE OF BIRTH: _____ SSN: _____ EMAIL: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME TELEPHONE: _____ CELL TELEPHONE: _____

EMERGENCY CONTACT: _____

INSURANCE: _____

LOCAL PHARMACY: _____

MAIL ORDER PHARMACY: _____

DRUG ALLERGIES: _____

CAN WE LEAVE MESSAGES ON YOUR VOICE MAIL/ANSWERING MACHINE? ❑YES ❑NO

WHO CAN PICK UP YOUR PRESCRIPTIONS? _____

WHO CAN WE TALK TO OTHER THAN YOUR SPOUSE?

Name: _____ Relationship: _____

Telephone: _____ Cellular Telephone: _____

PHYSICIANS' RELEASE & ASSIGNMENT

I authorize the release of any medical information necessary to process this claim, or for the purpose of scheduling any testing that my physician orders. I permit a copy of this authorization to be used in place of the original.

I am aware that my insurance claims are filed as a courtesy and do not relieve me of the responsibility to pay for these services if my carrier does not pay within a reasonable time period.

I hereby authorize F.E.C.M.G., Dr. Ludlima Mishelevich, to apply for benefits on my behalf for covered services by her or by her order. I request that payment from my insurance company be made directly to F.E.C.M.G., Dr. Ludmila Mishelevich. I certify that the Information I have reported with regard to my insurance coverage is correct, I permit a copy of this authorization to be used in place of the original. This authorizations may be revoked by either me or my insurance company at any time in writing.

SIGNATURE _____ DATE: _____