GULF COAST PHYSICIAN PARTNERS, P.A.

PATIENT INFORMATION: This refers to the Patient ONLY			
Name:		DOB:	
Social Security Number:	Language:	Male	Female
Employed: **Yes**___ Part-time___ Full-time___ **No**___ Unemployed___ Retired___ Disabled ___ **Student**___			
Occupation	Start Date (If applicable)		
Marital Status: Single Married Divorced Widowed			
Home Phone #:	Cell #:	Work #:	
Mailing Address:	City:	State:	Zip:
Physical Address:	City:	State:	Zip:
Race: Decline to Answer___ American Indian/Native Alaskan___ Asian___ Black/African American___ Pacific Islander ___ White ___ Other___			
Ethnicity: Decline to Answer__ Hispanic or Latino__ Non-Hispanic or Latino__ Unknown__			
EMAIL address:			
RESPONSIBLE PARTY: IF Patient is under age 18			
Relationship to Patient	Self____ (skip to back of page)	Parent/Guardian___	Spouse___
Name: (Last, First, MI)		DOB:	
Social Security#:		Male__	Female__
Home Phone #:	Cell#:	Work#:	
Mailing Address:	City:	State:	Zip:
Physical Address:	City:	State:	Zip:
EMAIL Address:			
SUBSCRIBER INFORMATION: Person who carries the insurance			
Relationship to Patient	Self___ (skip to back of page)	Parent/Guardian__	Spouse__
Name: (Last, First, MI)		DOB:	
Social Security #:		Male__	Female__
Home Phone#:	Cell#:	Work#:	
Mailing Address:	City:	State:	Zip:
Physical Address:	City:	State:	Zip:
EMAIL Address:			

Continued on back

INSURANCE INFORMATION

PRIMARY INSURANCE	
Name on card:	ID #:
Insurance Provider:	Group #:
SECONDARY INSURANCE	
Name on card:	ID #:
Insurance Provider:	Group #:
THIRD INSURANCE	
Name on card:	ID #:
Insurance Provider:	Group #:

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

I hereby authorize the office of Gulf Coast Physician Partners, P.A. to release any medical information required during the course of examination and treatment and permit directly to them any benefits due for their services rendered. I recognize and accept responsibility for services rendered regardless of insurance coverage. This includes but is not limited to co-insurance, co-payment, deductibles and non-covered services.

Patient Signature or Guardian Signature if patient is a minor

Date:

MEDICARE AUTHORIZATION

I request that the payment of authorized Medicare benefits be made either to me or on my behalf to Gulf Coast Physician Partners, P.A. for any services furnished to me by a physician or supplier. I authorize any holder of medical information about me to release to the HealthCare Financing Administration and its agents any information needed to determine these benefits payable for related services.

Patient Signature or Guardian Signature is patient is a minor

Date: