LISA WHIMS-SQUIRES, D.O.

PATIENT INFORMATION

1305 S. FT. HARRISON AVENUE, BUILDING G
CLEARWATER, FL 33756
PHONE (727) 466 – 9847 FAX (727) 466-0346

NAME (Last, First) …… DATE ……

DOB …….. AGE …… SEX ……M F RACE/ETHNICITY ……

SOCIAL SECURITY NUMBER …… LIVING WILL? Y N EMAIL …….

PHONE NUMBER …… ALTERNATE PHONE NUMBER …….

MARITAL STATUS S M D W Other SPOUSE NAME …….

FL ADDRESS ……OTHER ADDRESS ……..

…….. ……..

REASON FOR VISIT ……

REFERRING DOCTOR …….. PHONE # ……..

PRIMARY CARE DOCTOR IF DIFFERENT FROM ABOVE ……..

SPOUSE'S NAME…….

EMPLOYER ……..

WORK ADDRESS…….

WORK PHONE …… OCCUPATION ……

IN CASE OF EMERGENCY CONTACT ……..

RELATIONSHIP OF CONTACT PERSON …… PHONE ……..

LEGAL GUARDIAN …… PHONE …….

ADDRESS ……

INSURANCE ID …… POLICY …….

MEDICARE NUMBER …… …… …… …… …… …… …… . EFFECTIVE D ATE …… …… …… ..

LIFETIME AUTHORIZATION: MEDICARE/INSURANCE CERTIFICATION FOR PAYMENT

I certify that the information given by my in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carrier any information needed for this or related Medicare/Insurance claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the service or authorize such physician or organization to submit a claim to my carrier for payment. I am responsible for any co-payment and/or deductible.

SIGNED …….. DATE …….

If signed by someone other than beneficiary, state the title/relation and reason the patient was unable to sign.

……

WITNESSED BY …… DATE …….