



LIVE OAK MEDICAL ASSOCIATES

2896 Gulf Breeze Parkway
Gulf Breeze, Florida 32563
Office – 850.932.2203
Fax – 850.934.0050

PATIENT INFORMATION FORM

[PLEASE PRINT AND COMPLETE ALL INFORMATION]

PATIENT INFORMATION

Last Name: _____ First: _____ Middle _____

Address: _____ City _____ State _____ Zip _____

Date of Birth _____ Age _____ Social Security Number _____ Male () Female ()

Home Phone () _____ Work Phone () _____ Cell Phone () _____

Marital Status: Single Married Divorced Widow(er) Separated

Place of Employment: _____ Retired? Yes No

Person Responsible for Payment _____ Address _____

FAMILY INFORMATION

Spouse's Name: _____ If patient is a child, Parent's Name _____

Spouse/Parent's place of employment: _____ Phone#: _____

Emergency Contact Person: Name: _____ Phone #: _____

Relationship: _____

INSURANCE INFORMATION

Primary Insurance Company: _____ Policy ID# _____ Group# _____

Subscriber Name: _____ Subscriber Date of Birth: _____

Subscriber Social Security #: _____ Relationship to Patient: _____

Secondary Insurance Company: _____ Policy ID# _____ Group# _____



Subscriber Name: _____ Subscriber Date of Birth: _____

Subscriber Social Security #: _____ Relationship to Patient: _____

LIFETIME AUTHORIZATION ASSIGNMENT

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize my holder of medical information about me to release to the Social Security Administration, Medicare, or its intermediaries or carriers any information needed for this or related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician furnishing the service or authorize such physician or organization to submit to Medicare or payment for me. I request that this authorization also apply to other insurance.

Signature _____ Date _____