Palm Beach Physicians Group Inc

4601 North Congress Ave
West Palm Beach, FL 33407
(561) 840-4600

PATIENT INFORMATION

NAME (Last. First Middle)	MRN SSN#	BIRTHDATE	SEX

LOCAL ADDRESS	SECONDARY/BILLING ADDRESS (if Applicable)

CITY, STATE ZIP	HOME PHONE	CITY, STATE ZIP	HOME PHONE

PRIMARY CARE PHYSICIAN	REFERRING PHYSICIAN

PRIMARY EMPLOYER	SECONDARY EMPLOYER (if Applicable)
ADDRESS	ADDRESS
CITY, STATE ZIP	CITY, STATE ZIP
WORK PHONE	WORK PHONE

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)	SSN#	BIRTHDATE	SEX

LOCAL ADDRESS	SECONDARY/BILLING ADDRESS (if Applicable)
CITY, STATE ZIP	CITY, STATE ZIP
HOME PHONE	HOME PHONE
RELATIONSHIP TO PATIENT	

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY	POLICY#	
NAME OF INSURED	GROUP#	
ADDRESS OF INSURANCE COMPANY	COPAY AMT	
CITY, STATE ZIP	DEDUCTIBLE	
RELATIONSHIP TO PATIENT	EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY	POLICY#	
NAME OF INSURED	GROUP#	
ADDRESS OF INSURANCE COMPANY	COPAY AMT	
CITY, STATE ZIP	DEDUCTIBLE	
RELATIONSHIP TO PATIENT	EFFECTIVE DATE	EXPIRATION DATE

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.

SIGNATURE OF PATIENT/GUARDIAN_____ DATE:_____

AUTHORIZATION TO PAY RELEASE INFORMATION: I here by authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.

_____ _____

SIGNATURE OF PATIENT/GUARDIAN DATE

Palm Beach Physicians Group, Inc.
d/b/a Palm Beach Medical Group
4601 North Congress Avenue
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(561) 840-4600

Patient Contact Form

Patient Contact Information

All calls regarding your care, test results, and appointments will be made to your home telephone number. If you would like us to contact you at an alternate telephone number, please indicate that telephone number here:

(_____)_____

_____ I hereby authorize this medical practice to contact me by telephone and if I am not present, they may leave a message on my answering machine.

_____ Do ***NOT*** leave messages on answering machine other than name of caller and telephone number.

Other Contact Information

The following people other than a duly designated guardian or conservator are authorized to discuss my medical condition or billing information with a healthcare professional in this practice:

_____	_____	_____
Name	Relationship	Telephone Number
_____	_____	_____
Name	Relationship	Telephone Number
_____	_____	_____
Name	Relationship	Telephone Number

Patient Signature: _____ Date: _____

Print Name: _____ Telephone Number: _____

For Office Use Only

Signed Form Received By (Please Print): _____ Date: _____

Initials: _____