Seminole Sports & Family Medicine, PA

798 Executive Drive
Oviedo, FL 32765
Phone: (407) 359-8580 ● Fax: (407) 359-8364

Patient Registration Form

Patient Information

Name_____ Email Address_____

Street Address_____
Mailing Address_____
City, State, Zip_____
SSN#_____ Date of Birth_____
Sex : ☐Male ☐Female
Home Phone # (_____)_____ Work Phone # (_____)_____ Cell # (_____)_____
Best Phone # to Reach You (_____)_____
Marital Status (**Please check one**) ☐Single ☐Married ☐Divorced ☐Separated ☐Widow(er)

Race (**Please check one**)

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Multiracial
- ☐ Declined

Ethnicity (**Please check one**)

- ☐Hispanic or Latino
- ☐Non-Hispanic or Latino
- ☐Declined

Emergency Contact Information

Name_____ Relationship to Patient_____
Home Phone # (_____)_____ Alternate Phone # (_____)_____
May we share medical information with this person? (**Please check one**) ☐Yes ☐No

Legal Guardian (**If patient is under 18 or unable to make decisions for themselves**)

Name_____
Street Address_____
Mailing Address_____
City, State, Zip_____
SSN#_____ Date of Birth_____
Home Phone # (_____)_____
Best Phone # to Reach You (_____)_____
Relationship to Patient_____

What type of custody/guardianship do you have of this patient? (**Please provide a copy of documentation.)**
Sole _____
Shared with_____
None _____ Who has custody/guardianship?_____

Patient Name_____ Date of Birth_____

Primary Insurance Carrier
Name of Insurance Co_____
Name of Subscriber_____
Policy#_____
Group#_____
SSN#_____ Date of Birth_____
Relationship to Patient_____

Secondary Insurance Carrier
Name of Insurance Co_____
Name of Subscriber_____
Policy#_____
Group#_____
SSN#_____ Date of Birth_____
Relationship to Patient_____

Do you have a Living Will? (**Please check one**) ☐Yes ☐No (**Please ask our staff for an information packet**).
Do you have a Durable Power of Attorney for health care? If Yes, Name:_____
Do you have a Durable Power of Attorney for finances? If Yes, Name:_____
Please provide us with copies of your Durable Power of Attorney paperwork. .

Insurance Authorization and Assignment of Benefits
While we participate with many insurance plans, if we do not participate with your insurance carrier, you will be responsible for the entire balance for all services rendered. If we participate with your insurance carrier, you will be responsible for any co-payments and/or deductibles at the time the services are rendered. I authorize and assign insurance benefit payment directly to Seminole Sports & Family Medicine, PA for any medical services I receive. I understand and agree that I am ultimately responsible for the charges on my account for any professional services rendered. I will be responsible for payment in full of all balances not paid by my insurance company. In an effort to help ensure accurate insurance billing, we ask that you present your insurance card and photo ID at each visit. Acceptable forms of payment are cash, check, debit and credit card(MasterCard, Visa).
I have received a copy of the Seminole Sports & Family Medicine, PA Payment Policy.

Notice of Privacy Practices
I have received/was offered a copy of the Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed and explains my rights as a patient. I understand that I should read this document carefully and that it may be changed at any time. I may obtain a copy of the Notice of Privacy Practices by calling Seminole Sports & Family Medicine, PA at (407)359-8580.

The Seminole Sports & Family Medicine, PA staff and providers look forward to establishing a good working relationship with you. We ask that you provide a 24-hour notice if you are not able to keep a scheduled appointment. There will be a charge of $25 for missed appointment. After three (3) confirmed appointments missed without prior notice, we reserve the right to discharge you from the practice.

I consent to evaluation and treatment. To ensure continuity of care, I hereby authorize release of medical information that is necessary for my further treatment by a specialist that my Primary Care Provider may refer me to for care.

Patient Name (please print) _____

Signature _____ Date _____

Legal Guardian _____ Date _____