



Patient Information

Category
 1 2 3 4 5
 Priv. MC WC Auto CA
 6 7 8 9 10 11
 HMO Liab MCD Other PPO Champ

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Name (Last) _____	(First) _____	M.I. _____	Date _____
Local Address _____			
City _____	State _____	Zip _____	
Permanent Address _____			
City _____	State _____	Zip _____	
Home Phone _____	Work Phone _____		
Date of Birth _____	SS # _____		
Marital Status _____	Spouse's Name _____		

Employer _____	Occupation _____
Address _____	City _____ State _____ Zip _____
Employer Phone # _____	

Name of Nearest Relative Not Living with You _____
Address _____ City _____ State _____ Zip _____
Emergency Phone # _____

Primary Insurance _____	ID # _____	Group # _____	Phone # _____
Secondary Insurance _____	ID # _____	Group # _____	Phone # _____
How were you referred to SFGA? _____			
Primary Care Physician _____			
Allergies to Medication _____			
Languages Spoken _____			

I hereby authorize SFGA to perform treatment that the doctor deems necessary and the Doctor and I agree upon.

YOUR SIGNATURE IS NECESSARY FOR US TO PROCESS ANY INSURANCE CLAIMS AND TO INSURE PAYMENT OF SERVICES RENDERED

The Non-Medicare Patient: I authorize the release of all medical information necessary to process this claim and that is pertinent to my medicare care. I assign all medical and/or surgical benefits, including major medical benefits to which I am entitled to Physician/Clinic. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. The Medicare Patient/Lifetime Authorization: I request that payment of authorized Medicare benefits be made to me or on my behalf to Physician/Clinic for any services furnished me by that provider. I authorize any holder of medicare information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ THIS INFORMATION AND UNDERSTAND IT.

Signature _____ Date _____

Form # 003 - 10/06, GG

1325 Congress Ave., Ste. 211 Boynton Beach, FL 33426 Phone (561) 732-2900 Fax (561) 738-7055	7270 W. Boynton Beach Blvd. Boynton Beach, FL 33437 Phone (561) 738-5772 Fax (561) 738-0096	160 JFK Drive, Ste. 103 Atlantis, FL 33462 Phone (561) 434-0060 Fax (561) 434-0086	4675 Linton Blvd., Ste. 204 Delray Beach, FL 33484 Phone (561) 496-0808 Fax (561) 496-3728	10151 Enterprise Ctr. Blvd.#106 Boynton Beach, FL 33437 Phone (561) 737-0211 Fax (561) 737-7433	1447 Medical Pk Blvd. #405 Wellington, FL 33414 Phone (561) 434-0060 Fax: (561) 434-0086
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