GULF COAST PHYSICIAN PARTNERS, P.A.

PATIENT INFORMATION: THIS SECTION REFERS TO THE PATIENT ONLY

Name *(Last, First, M.I.)*: ☐ M ☐ F	DOB:
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Social Security Number:	Email:
Phone #:	Cell #:
Physical Address: _____ City: _____ State ____ Zip Code: _____	
Mailing Address (if different): _____ City: _____ State ____ Zip Code: _____	
☐ African American ☐ Alaskan Native	☐ Asian or Pacific Islander
☐ Caucasian ☐ East Indian	☐ Hispanic
☐ Native American ☐ Other _____	Employer:
Primary Language spoken: _____	Work #
If Student ☐Full Time ☐ Part Time	Name of School:

RESPONSIBLE PARTY: THE SECTION BELOW REFERS TO THE PERSON WHO SHOULD RECEIVED THE BILL

Name *(Last, First, M.I.)*: ☐ M ☐ F	DOB:
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Social Security Number:	Email:
Phone #:	Cell #:
Physical Address: _____ City: _____ State ____ Zip Code: _____	
Mailing Address (if different): _____ City: _____ State ____ Zip Code: _____	
Relationship to Patient: ☐ Self (skip to page 2)	☐ Parent/Guardian ☐ Spouse
Employer:	Phone #:

SUBSCRIBER INFORMATION: THE SECTION BELOW REFERS TO THE PERSON WHOSE NAME IS ON THE INSURANCE

Name *(Last, First, M.I.)*: ☐ M ☐ F	DOB:
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Social Security Number:	Email:
Phone #:	Cell #:
Physical Address: _____ City: _____ State ____ Zip Code: _____	
Mailing Address (if different): _____ City: _____ State ____ Zip Code: _____	
Relationship to Patient: ☐ Self (skip to page 2)	☐ Parent/Guardian ☐ Spouse
Employer:	Phone #:

Please ensure the office has a copy of your most recent insurance card(s) and current driver's license

INSURANCE COVERAGE INFORMATION: Please show all numbers on your card

PRIMARY INSURANCE COVERAGE	
Insured (Name on card)	Insured ID Number:
Insured Company Name	Group/Member/Policy Number
Address	Effective date

SECONDARY INSURANCE COVERAGE	
Insured (Name on card)	Insured ID Number:
Insured Company Name	Group/Member/Policy Number
Address	Effective date

THIRD INSURANCE COVERAGE	
Insured (Name on card)	Insured ID Number:
Insured Company Name	Group/Member/Policy Number
Address	Effective date

IN CASE OF EMERGENCY

NAME, PHONE AND RELATIONSHIP OF THE NEAREST RELITIVE *NOT* LIVING WITH YOU:

_____

AUTHORIZATION TO PAY BENEFITS TO THE PHYSICIAN

I hereby authorize the office of Gulf Coast Physicians Partners, P.A. to release any medical information required during the course of examination and treatment and permit directly to them any benefits due for their services rendered. I recognize and accept responsibility for services rendered regardless of insurance coverage. This includes but is not limited to coinsurance, co-payment, deductible and non-covered services.

_____ Date _____

Signature of Patient or Guardian, if Patient is a minor

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Gulf Coast Physician Partners, P. A. for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

_____ Date _____

Signature of Patient or Guardian, if Patient is a minor

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS TO ANOTHER PERSON

I hereby authorize **Gulf Coast Physician Partners** to release medical information on myself.

Name_____ DOB: _____

To_____

(relationship to patient)_____

I hereby grant Gulf Coast Physician Partners approval to discuss my medical history as outlined below. Any exclusions will be noted. This authorization will remain in effect until rescinded by me in writing. Gulf Coast Physician Partners may release this information

____In Person

____Via Telephone

Notice

This authorization is for full disclosure of pertinent records, including clinical findings, diagnosis, treatment, assessment, recommendations for further care, and dates of hospitalizations and clinic visits. If you do not want any information that may be related to drug, alcohol, psychiatric conditions, and/or sexually transmitted diseases, including HIV/AIDS information released to the above individual/agency indicate below what portions of the record you would like excluded.

Exclusions: _____

These records are confidential and not for re-release by any facility other than Gulf Coast Physician Partners.

_____

Patients Signature

_____ _____

Witness Date

Authorization for Release of Medical Records

Please complete and fax, mail or return to
Gulf Coast Physician Partners, PA
5992 Berryhill Road, Suite 300, Milton, FL 32570
Phone (850) 623-9787 / Fax (850) 626-7512

**REQUIRED FIELDS

**Patient: _____ Phone: _____
**DOB _____ **SSN: _____
Address: _____
City: _____ State: _____ Zip: _____

I hereby authorize Gulf Coast Physician Partners, PA to receive information from my medical records from:

**Doctor/Facility Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone _____ Fax _____

**Information to be released:

Entire File_____ or History & Physical_____ Progress Notes_____ Labs_____
X-Ray Reports_____ Other: _____
All Dates_____ or Dates of Service, from_____ to _____

Purpose of Disclosure:

Changing Physicians_____ School_____ Continuing Care_____ Workers Comp_____
Insurance_____ Legal_____ Consultation/Second Opinion_____
Other (Please Specify) _____

***I understand that any alcohol, drug abuse, mental health, psychotherapy, HIV/AIDS/STD's, if present, will be disclosed with this authorization. To exclude this information, please sign here_____**

***I understand I may revoke this authorization at any time by notifying the providing organization in writing and it will be effective on the date notified except to the extent, action has already been taken in reliance upon it.**

***I understand information disclosed may be subject to re-disclosure and is no longer protected.**

***I understand there will be a fee associated with all records being sent to insurance companies, attorneys, and myself.**

Patient Signature: _____ Date_____
Or Legal Guardian_____ Date_____

This release expires upon completion.