Emerald Coast Internal Medicine And Geriatrics

Date:_____ Home:(_____)_____

Cell:(_____)_____

Name:_____ SS#:_____

Last First Middle

Address:_____

City/State/Zip code:_____

Sex: M F Age: _____ DOB:_____ Married Widowed Single Divorced Seperated

Patient Employer/School:_____ Occupation:_____

Whom may we thank for referring you? _____

In case of emergency who should be notified?_____

Phone:_____

Relation To Patient:_____

Primary Insurance:_____

Person Responsible For Account:_____

Relation to Patient:_____

Secondary Insurance:_____

Person Responsible For Account:_____

Relation to Patient:_____

Assignment and Release

I certify that I, and my dependent(s) have insurance coverage with _____.
And assign Directly to Dr.Emad Eisa at Emerald Coast Internal Medicine and Geriatrics all insurance benefits, if any, otherwise payable to me for services rendered, I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Dr.Emad Eisa may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for service and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or in one year from the signed date below.

Signed by:_____ _____

(Signature of Patient or Legal Guardian) (Relationship to patient)

_____ _____

(Please Print Name) (Date)