

# Patient Information Form

## Patient Info

Date: \_\_\_\_\_ Patient SS#: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone #: \_\_\_\_\_ Local #(if visiting): \_\_\_\_\_

Referred by: \_\_\_\_\_

## Guarantor Info

Parent/Guardian Name: \_\_\_\_\_ DOB: \_\_\_\_\_

SS#: \_\_\_\_\_

## Insurance Info

Insurance Name: \_\_\_\_\_ HMO or PPO ? (circle one)

Name of Insured: \_\_\_\_\_ ID#: \_\_\_\_\_

SS# of Insured: \_\_\_\_\_ Group #: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone#: \_\_\_\_\_

## Next of Kin Info

Name: \_\_\_\_\_ Phone#: \_\_\_\_\_

Address: \_\_\_\_\_

## Authorizations

I hereby authorize and consent to medical care and/or minor surgical care deemed advisable by the doctor on duty at the time of my visit in order to diagnose and provide treatment. In addition, I fully understand office policy regarding medical fees and agree to payment of fees at time professional services are rendered.

I understand that any lab specimens drawn or collected here, that is not performed here, will be sent to an independent laboratory and will be billed separately by the independent laboratory.

I agree to be fully responsible for all charges including any legal fees and/or collection fees in the event of non-payment.

\_\_\_\_\_  
**Initial**

I hereby authorize Care Plus Walk-in Clinics to release any and all medical information in connection with services rendered for health insurance purposes. I also hereby give my permission to send a copy of my medical records to my primary care physician's office. I release the facility from any liability which may arise as a result of the use of information contained in the records listed.

I hereby authorize my insurance carrier to mail payment directly to Care Plus Walk-in Clinics for any medical and/surgical services.

\_\_\_\_\_  
**Initial**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature Parent/Guardian

\_\_\_\_\_  
Date

16688 N DALE MABRY  
TAMPA, FL 33618

CARE PLUS  
WALK IN CLINICS  
519A E. BLOOMINGDALE AVE  
BRANDON, FL 33511

14462 BB DOWNS BLVD  
TAMPA, FL 33613