Emerald Coast Diabetes & Nutrition Center

PATIENT INFORMATION Date: _____

Patient Name:_____
First Middle Initial Last

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____)_____ Cell/Work Phone (_____)_____

Soc Sec #: _____-_____-_____ Date of Birth: _____ Gender: _____

Marital Status: S M D W Email address: _____

Employer: _____Occupation: _____

Emerg Contact Name: _____ Emerg Contact Phone #: (_____)_____

Relationship to Patient: _____

RESPONSIBLE PARTY INFORMATION/INSURANCE INFORMATION (copies of insurance cards required)

Primary Insurance: _____ Effective Date: _____

Name of Insured/Subscriber: _____ Relationship: _____

Insured's Date of Birth: ____/____/____ Insured's ID#:_____ Group #: _____

Secondary Insurance: _____ Effective Date: _____

Name of Insured/Subscriber: _____ Relationship: _____

Insured's Date of Birth: ____/____/____ Insured's ID#:_____ Group #: _____

ASSIGNEMENT OF INSURANCEINFORMATION & BENEFITS/RELEASE OF MEDICAL INFORMATION: I hereby authorize Emerald Coast Diabetes & Nutrition Center and It's Providers to release any information needed to secure payment. I authorize that all benefits by my insurance company be paid directly to Emerald Coast Diabetes & Nutrition Center and understand that I am financially responsible for all charges incurred that are not covered in full by my insurance. In addition, I hereby authorize the release of all applicable medical information including and without limitation, copies of all records and test results produced to the referring provider and or for follow up providers and such other health care practitioners or organizations who/which will be providing subsequent monitoring of care or treatment in connection with the care provided by the Emerald Coast Diabetes & Nutrition Center and It's Providers.

SIGNATURE OF RESPONSIBLE PARTY:_____ Date: _____

Acknowledgement of Privacy Practice and Patient Bill of Rights

1. Patient Rights: A copy of my Patient Rights has been made available to me.
2. Notice of Privacy Practice: A copy of Emerald Coast Diabetes & Nutrition Center's Privacy Practice has been made available to me.

_____ _____ _____

Signature of Patient (or Legal Guardian/Representative Date Relationship to Patient