SOUTHWEST INTERNAL MEDICINE SPECIALISTS

Diplomats, American Board of Internal Medicine

M.J. GALCERAN, M.D. APARNA HERNANDEZ, M.D.

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PATIENT REGISTRATION

PATIENT NAME _____
Last First Initial

HOW DID YOU HEAR ABOUT US? _____

Home Address _____

City _____ State _____ Zip _____ Date of Birth _____

Mailing Address (if different) _____

Male/Female _____ Social Security Number _____ Marital Status _____

Home Phone _____ Cell Phone_____

Employer _____ Occupation _____ Telephone_____

Friend or Relative not living With You:

Name _____ Relationship _____

Address _____ Telephone _____

Medical Insurance Information:

1.Primary Insurance _____Policy Holder_____
DOB:_____ SSN#:_____

2. Secondary Insurance _____ Policy Holder _____

Name of Spouse or (if a minor) parent _____

Spouse's/Parent's Employer _____ Telephone _____

Authorization and Assignment

I hereby authorize my insurance carrier, attorney or any third-party payer to pay directly to Southwest Internal Medicine Specialists all charges submitted for services incurred by me. I understand I will be responsible for any and all charges not paid by my insurance company. I authorize Southwest Internal Medicine Specialists to release information concerning my medical condition to my insurance company, employer, hospital, physician or attorney for the purpose of processing a claim. I assign payment directly to the physicians at Southwest Internal Medicine Specialists which may be due from the Medicare program or any other insurance company, including supplemental insurance, which may cover in whole or part medical services which I have received. The authorization and assignment shall be valid until I notify Southwest Internal Medicine Specialists in writing of the cancellation. A photocopy of this authorization shall be valid as the original copy.

_____ _____ _____ _____
Signature Date Signature (WITNESS) Date

5979 Vineland Road, Suite 310, Orlando, FL 32819 (407) 345-0005