ENDOCRINE ASSOCIATES OF FLORIDA, P.A.
PATIENT REGISTRATION

PLEASE PRINT CLEARLY

PATIENT LAST NAME		FIRST NAME		MIDDLE NAME
ADDRESS STREET		APT NO. CITY		STATE ZIP CODE
SOCIAL SECURITY NUMBER	DATE OF BIRTH	AGE	GENDER	PREFERRED LANGUAGE
HOME PHONE	MOBILE PHONE		WORK PHONE	
PREFERRED PHONE (CHECK ONE) [ ] HOME [ ] MOBILE [ ] WORK	EMAIL ADDRESS			
EMPLOYED BY			OCCUPATION	
EMPLOYER'S ADDRESS			CITY, STATE	ZIP CODE
IF MINOR, PARENT/GUARDIAN NAME			RELATIONSHIP	
OCCUPATION	HOME PHONE		MOBILE PHONE	WORK PHONE
PREFERRED PHONE (CHECK ONE) [ ] HOME [ ] MOBILE [ ] WORK	EMAIL ADDRESS			
RACE (CHECK ONE) [ ] AMERICAN INDIAN/ALASKAN NATIVE [ ] ASIAN [ ] CAUCASIAN/WHITE [ ] NATIVE HAWAIIAN/PACIFIC ISLANDER [ ] BLACK/AFRICAN AMERICAN [ ] DECLINED				ETHNICITY (CHECK ONE) [ ] HISPANIC [ ] NON-HISPANIC [ ] DECLINED

Insurance Information

POLICY HOLDER'S NAME _____ RELATIONSHIP TO PATIENT _____

DATE OF BIRTH _____ SOCIAL SECURITY NUMBER _____

INSURANCE COMPANY NAME — POLICY NO. OR CERTIFICATE NO.

PRIMARY _____ _____

INSURANCE CO. ADDRESS _____ TELEPHONE NO. _____

SECONDARY _____ _____

INSURANCE CO. ADDRESS _____ TELEPHONE NO. _____

Emergency Contact Information

NEXT OF KIN/REFERENCE INFORMATION

NAME OF NEAREST RELATIVE OR FRIEND _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ CITY, STATE, ZIP CODE _____

HOME PHONE _____ MOBILE PHONE _____ BUSINESS PHONE _____

PRIMARY CARE PHYSICIAN'S NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

TELEPHONE _____ FAX _____

REFERRING PHYSICIAN'S NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

TELEPHONE _____ FAX _____

LIFETIME AUTHORIZATION: I understand that me medical insurance is a contract between my insurance company and MYSELF. I am responsible for payment of services at time they are rendered by Victor L. Roberts M.D./Jose M. Mandry M.D. I authorize the release of any medical information necessary to process the claim for payment of insurance benefits. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I authorize my insurance company to pay medical benefits to Victor L. Roberts M.D./Jose M. Mandry M.D. For services rendered. Further, I authorize treatment of my condition.

Preferred Method of Payment: [ ] Cash [ ] Mastercard, Visa, Amex, Discover

*** **Please note: Checks are no longer accepted.**

_____ _____

Signature of Patient, or Parent, or Responsible Party — Date