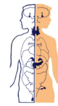
ENDOCRINE ASSOCIATES OF FLORIDA, P.A.
PATIENT REGISTRATION



PLEASE PRINT CLEARLY

LAST NAME	FIRST NAME	MIDDLE NAME

STREET ADDRESS	APT NO.	CITY	STATE	ZIP

PREFERRED LANGUAGE	DATE OF BIRTH	GENDER M [ ] F [ ] O [ ]	MARITAL STATUS (CHECK ONE) SINGLE [ ] MARRIED [ ] DIVORCED [ ] WIDOWED [ ]

PREFERRED PHONE (CHECK ONE) HOME [ ] MOBILE [ ] WORK [ ]	HOME PHONE	MOBILE PHONE	WORK PHONE

EMAIL ADDRESS	RACE (CHECK ONE) AMERICAN INDIAN/ALASKAN NATIVE [ ] ASIAN [ ] CAUCASIAN/WHITE [ ] BLACK/AFRICAN AMERICAN [ ] OTHER [ ] DECLINED [ ]	ETHNICITY (CHECK ONE) HISPANIC [ ] NON-HISPANIC [ ] DECLINED [ ]

EMPLOYMENT STATUS (CHECK ONE) FULL TIME [ ] PART TIME [ ] NOT EMPLOYED [ ] STUDENT [ ] RETIRED [ ]	OCCUPATION

EMPLOYED BY	STREET ADDRESS	CITY	STATE	ZIP

IF MINOR, PARENT/GUARDIAN NAME	RELATIONSHIP	PREFERRED PHONE

	HOW DID YOU HEAR ABOUT US? FAMILY/FRIEND [ ] PHYSICIAN [ ] INSURANCE COMPANY [ ] INTERNET [ ]	REFERRED BY

Insurance Information

POLICY HOLDER'S NAME ______________________ DATE OF BIRTH ______________

RELATIONSHIP TO PATIENT ______________________

TYPE OF INSURANCE (CHECK ONE)
GOVERNMENT [ ] EMPLOYER [ ]

INSURANCE COMPANY NAME POLICY NO.

PRIMARY ______________________ ______________

INSURANCE CO. ADDRESS ______________________ TELEPHONE NO. ______________

SECONDARY ______________________ ______________

INSURANCE CO. ADDRESS ______________________ TELEPHONE NO. ______________

Emergency Contact Information

NAME OF NEAREST RELATIVE OR FRIEND ______________________ RELATIONSHIP TO PATIENT ______________

ADDRESS ______________________ CITY, STATE, ZIP ______________

HOME PHONE ______________ MOBILE PHONE ______________ EMAIL ADDRESS ______________

PRIMARY CARE PHYSICIAN ______________	**REFERRING PHYSICIAN NAME** ______________
ADDRESS ______________	ADDRESS ______________
CITY ______ STATE ______ ZIP ______	CITY ______ STATE ______ ZIP ______
TELEPHONE ______ FAX ______	TELEPHONE ______ FAX ______

LIFETIME AUTHORIZATION: I understand that my 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./Lucy Duque-Roberts, DNP-C. 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./Lucy Duque-Roberts, DNP-C for services rendered. Further, I authorize treatment of my condition.

______________________________ ______________

Signature of Patient, or Parent, or Responsible Party Date