SEACOAST MEDICAL
ASSOCIATES

Patient Name:
Date of Birth:
SSN:
Tel Num:
Work Num:
Street Address:
Mailing Address:
Email Address:

Insurance Information:
Primary Insurance:
Insurance Address:
Subscriber Num:
Subscriber Name:
Relation to Patient:

Secondary Insurance:
Insurance Address:
Subscriber Num:
Subscriber Name:
Relation to Patient:

Misc Info:
Employer Name:
Employer Address:
Emergency Contact Info:
Pharmacy Info:

I hereby authorize payment directly to the undersigned physician of the Surgical and/or Medical benefits otherwise payable to me for his services as described below but not to exceed the reasonable and customary charge for those services. I acknowledge that I have been made aware of the privacy policy of this office, as it pertains to the privacy and confidentiality of my medical records.

_____ _____

SIGNED (patient) If under 18 years of age, parent or guardian DATE

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