

Express Care Of Tampa Bay, INC

6496 US 41 N. Apollo Beach. Fl. 33572 Tel: 813-641-0068

107

Robertson St. Brandon. Fl. 33511 Tel: 813-651-4100		(Former Name)		Birth Date	Age	Sex
Is this your legal name? If not, what is your legal name?		REGISTRATION FORM				
<input type="checkbox"/> Yes		<input type="checkbox"/> NO				
Street Address	City	State	ZIP Code	Social Security#	Home Phone No.	
P.O. Box	City	State	ZIP Code			
Occupation	Employer	Employer Phone No.				
Chose Clinic Because/Referred to Clinic by (Please check one box)			<input type="checkbox"/> Dr.	<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital	
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to Home/Work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other		
Other Family Members Seen Here						
Reason For Today's Visit::						

INSURANCE INFORMATION**(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)**

Person Responsible for Bill	Birth Date	Address (if different)		Home Phone No.		
Is this person a patient here?						
<input type="checkbox"/> Yes		<input type="checkbox"/> No				
Occupation	Employer	Employer Address		Employer Phone No.		
IS this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Please indicate primary insurance		<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid	<input type="checkbox"/> United	<input type="checkbox"/> Tr-care	<input type="checkbox"/> BS/BC
<input type="checkbox"/> Humana	<input type="checkbox"/> Aetna	<input type="checkbox"/> Cigna	Other			
Subscriber's Name	Subscriber's Social Security #	Birth Date	-	Group #	Policy #	
Co-Payment amount \$ _____						
Patient's Relationship to Subscriber	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
Name of Secondary Insurance (if applicable)	Subscriber's Name	Group #	Policy #			
Patient's Relationship to Subscriber	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Patient	Work Phone No	Home Phone No.

Consent For treatment: The undersigned authorizes the provider Express care to furnish medical treatment to include any necessary procedures. The above information is true to the best of my knowledge. I authorize my insurance Medicare Patients: I have been given ABF notice, please initial _____ I am aware of HIPPA Policy initial _____ benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Express Care Clinic or insurance company to release any information required to process my claims. Refill X _____

PATIENT/GUARDIAN SIGNATURE Medication after 5 (five) days.
Witness

DATE