ADULT AND GERIATRIC CENTER OF SOUTH FLORIDA

PATIENT REGISTRATION FORM

Please be sure to fill out ALL FIELDS

Last Name: ________________ First Name: ________________ Middle: ________________

Address: ____

City: __________________ State: ________________ Zip Code: ________________

Home Phone: ________________ Cell Phone: ________________ Work: ________________

Marital Status: Single _____ Married _____ Separated _____ Divorced _____ Widowed _____

Sex: Male _____ Female _____

Social Security #: Date of Birth:

Do you have a Living Will? Yes _____ No _____ (If Yes, please provide office with a copy)

Race: Caucasian _____ African _____ American _____ Asian _____ Hispanic _____ Pacific Islander _____ Other ____________________

Preferred Language: English _____ Spanish _____ Other ___________________

Email: ____

Pharmacy Name: ________________________________ Pharmacy#: _____________________

Pharmacy Address: ____

Primary Physician Name: _____________________________ PCP Phone #:. _______________

Employment: Full-Time _____ Part-Time _____ Retired _____ Student _____

Employer name: ____

Employer Address: ____

Emergency contact First Name _______________________ Last Name ___________________

Address:____

City: ______________________________ State: __________________ Zip Code: ___________

Home Phone: _______________ Work Phone: ________________ Cell Phone: _____________

Relationship: ___________________________

Patient Signature: _____________________________ Date: __________________________

The above Information is true lo the best of my knowledge. I authorize my Insurance benefits be paid directly to the physician. I understand that i am financially responsible for any balance. I also authorize Adult and Geriatric Center of South Florida, or Insurance company to release any information required to process my calms. If Medicare is my only Insurance carrier, I understand that I am fully responsible for my coinsurance