Oriental Medical Center, Mai Tar

7362 Futures Drive / Suite 1 / Orlando / FL / 32819

Patient Registration

Please Print Clearly Answer all questions on **BOTH** sides, If Not Applicable write in "N/A" **DO NOT LEAVE BLANK SPACES**			
Name	(First)	(Middle Initial)	(Last)
Marital Status: _____Single _____Married ____Separated _____Divorced ____Widowed			
Date of Birth (Month/Day/Year)	Age		**Social Security Number**
Home Address	(Street)		
(City, State & Zip Code)			
Telephone Numbers/Email (Home) _____ (Cell/Beeper)_____ (Work) _____ (Fax) _____ (Email) _____			
Employer Name		Occupation	
(Street)		(City, State & Zip Code)	
In Case of Emergency, Notify	Telephone Number		Relationship
Referred to us by:			
Insurance Information ____ Private Insurance ____Workmen's Comp ____ Personal Injury (Liability) ____Self-Pay			
Insurance Company Name		(Street)	
Telephone Number		(City, State & Zip Code)	
Policy, Claim or Group Number		**Name of Insured, if other than self**	
Deductible Amount		(Street)	
How much has been met?		(City, State & Zip Code)	

AUTHORIZATION TO PAY PHYSICIAN – I hereby authorize payment of Medical benefits to _____ Oriental Medical Center, Mai Tar as payment toward the total charges for Professional Services rendered. A photocopy of this Assignment shall be considered as effective and valid as the original. I clearly understand and authorize the release of any medical or other information necessary to process any of my insurance claims. I also request payment of government benefits either to myself or the party who accepts assignment above.

Signature of Policyholder _____ **Date** _____