



## PATIENT INFORMATION

### PATIENT INFORMATION - PLEASE PRINT

Last Name		First Name		M.I.	Marital Status	
Mailing Address			City	State	Zip	
Home Phone		Work Phone		Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>		
DOB / /	SS#		Driver's Lic#			
Employer's Name			Reason for Visit			
How Were You Referred To This Office?						
Hospital <input type="checkbox"/> Radio <input type="checkbox"/> Newspaper <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Employer <input type="checkbox"/> Phone Book <input type="checkbox"/> Doctor <input type="checkbox"/>						
If Doctor, Whom?						

### RESPONSIBLE PARTY IF OTHER THAN PATIENT

Last Name		First Name		M.I.
Mailing Address			City	State/Zip
Home Phone		Work Phone		SS#
Driver's License No.			Relationship to Patient	

### IF THIS WAS AN ACCIDENT FILL OUT QUESTIONS BELOW

Was This Job Related? Yes <input type="checkbox"/> No <input type="checkbox"/>		Date of Accident	
Was This An Accident? Yes <input type="checkbox"/> No <input type="checkbox"/>		Date of Accident	
How Did Accident Happen?			
Do You Have An Attorney Representing You For This? Yes <input type="checkbox"/> No <input type="checkbox"/>		Name	Phone ( )

### INSURANCE INFORMATION

Insurance Company		Phone	SECONDARY CARRIER	
Address			Insurance Company	
City/State/Zip			Address	
I.D. No. / Medicare No.			City/State/Zip	
Group Name or No.			I.D. No. / Medicare No.	
Insured's Last Name		First Name	Group Name or No.	
DOB / /		Address	Insured's Last Name	
City/State/Zip			First Name	
Relationship to Guarantor? Self <input type="checkbox"/> Wife <input type="checkbox"/> Husband <input type="checkbox"/>			DOB / /	
Child <input type="checkbox"/> Parent <input type="checkbox"/> Other <input type="checkbox"/>		Employer Ins. Plan? Yes <input type="checkbox"/> No <input type="checkbox"/>	Address	
Child <input type="checkbox"/> Parent <input type="checkbox"/> Other <input type="checkbox"/>		Employer Ins. Plan? Yes <input type="checkbox"/> No <input type="checkbox"/>	City/State/Zip	

### IN CASE OF EMERGENCY, WHO SHOULD WE CALL?

Name	Relationship	Home Phone ( )
Street Address	Work Phone ( )	
	City/State/Zip	

### CONSENT FOR TREATMENT AND LIFETIME AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE

I hereby give consent to LCO GROUP, P.A., dba FLORIDA MUSCULOSKELETAL INSTITUTE to provide treatment they may deem necessary as discussed with the patient.

I understand that I am responsible for charges incurred for services. I understand I am responsible for charges not covered by the insurance policy or Medicare and should it become necessary to collect these charges through an attorney or other collection process, I shall be responsible for all court costs, interests, collection costs and attorney's fees.

I hereby request payment of authorized Medicare benefits and/or any other including supplemental insurance benefits for me to be paid directly to LCO GROUP, P.A., dba FLORIDA MUSCULOSKELETAL INSTITUTE for any services furnished me by LCO GROUP, P.A., dba FLORIDA MUSCULOSKELETAL INSTITUTE. I authorize LCO GROUP, P.A., dba FLORIDA MUSCULOSKELETAL INSTITUTE and staff to release to my insurance carrier and its agents any information concerning health care, advice, treatment or supplies provided me, needed to determine these benefits or the benefits payable for related services.

\_\_\_\_\_  
SIGNATURE PATIENT AUTHORIZATION

\_\_\_\_\_  
Date

\_\_\_\_\_  
SIGNATURE OF RESPONSIBLE PERSON

\_\_\_\_\_  
Date