

Fort Meade Medical Center

25 N. Lanier Avenue
Fort Meade, FL 33841

Patient Registration

Date _____ Soc. Security # _____ Referred By _____
Date of Birth _____ Male/Female (Circle one) Marital Status _____
Patient Last Name _____ First _____ Middle _____
Mailing Address _____ Apt # _____
City _____ FL _____ Zip Code _____ Home Phone # () _____
Out of State Address _____

Employer _____ Occupation _____ Phone # () _____
Address _____ City _____ State _____ Zip Code _____
Emergency Contact _____ Relationship _____
Address _____ City _____ State _____ Zip Code _____
Home Phone () _____ Business Phone () _____

Medicare Number _____ Medicaid Number _____
Insurance Name _____ Policy/Cert. # _____
Group Name _____ Group Number _____
Insurance Address _____ City _____ State _____ Zip Code _____
Insurance Phone # () _____ Name of Insured _____
Relationship to Patient _____ Soc. Sec # _____ Date of Birth _____
Address _____
Insurance Name _____ Policy/Cert. # _____
Group Name _____ Group Number _____
Insurance Address _____ City _____ State _____ Zip Code _____
Insurance Phone # () _____ Name of Insured _____
Relationship to Patient _____ Soc. Sec # _____ Date of Birth _____
Address _____

Authorization to Release Information and to Pay Benefits:

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

I request that this authorization also apply to all other insurances.

Signature _____ Date _____

PAYMENT IN FULL IS REQUIRED AT THE TIME OF YOUR VISIT