ORLANDO MEDICAL CENTER

7800 LAKE UNDERHILL ROAD
ORLANDO, FL 32822
Ph: (407) 282-2244 ♦ Fax: (407) 282-2002

PLEASE PRINT

Patient Last Name:	**First**	MI	Date:
Address:	City	Zip Code	**Home Phone #**
Sex: M F (circle)	DOB	Social Security #	Marital Status
Patient Occupation	Employer	Employer Address	**Cell Phone #**
Spouse's Name	Employer	DOB	**E-mail Address:**
Responsible Party Name:	Relationship:	Social Security #	DOB:
Guarantor Employer	Employer Address		Work Phone #

Primary Insurance			**Secondary Insurance**		
Address		Phone #	Address		Phone #
Member ID / Policy #		Group / Code #	Member ID / Policy #		Group / Code #
Subscriber Name	DOB	SS #	Subscriber Name	DOB	SS #
Subscriber's Relation to Patient			Subscriber's Relation to Patient		
Emergency Contact Name		**Phone #**	**Relationship**		
Person Name we can release personal medical information			**Phone #**		**Relation:**

My signature below is authorization for Orlando Medical Center to file insurance claims and to accept assignment on my behalf for all services rendered by Orlando Medical Center Physicians and staff. I also authorize release of any medical records required by my insurance company to process these claims. I agree that this authorization shall be in effect until such time as I request it to be withdrawn. My signature below also indicates that I have received Orlando Medical Center privacy Procedure HIPAA Policy handout.

Signature of Patient or Guardian **Date**