EMERALD COAST FAMILY MEDICINE

Date:_______________

PATIENT INFORMATION

First Name	Middle	Last	Male ☐ Female ☐	Date of Birth

Address	City	State	Zip Code

Primary Phone	SS Number
Secondary Phone	Email

PRIMARY POLICY HOLDERS INFORMATION

First Name	Middle	Last	Male ☐ Female ☐	Date of Birth

Primary Phone	SS Number
Secondary Phone	Email

Primary Insurance	Policy ID	Insurance Phone Number

SECONDARY POLICY HOLDERS INFORMATION

First Name	Middle	Last	Male ☐ Female ☐	Date of Birth

Primary Phone	SS Number
Secondary Phone	Email

Primary Insurance	Policy ID	Insurance Phone Number

EMPLOYER INFORMATION

Company	Phone Number

Address	City	State	Zip Code

Insurance Verified By:_______________________________

*****It is the office policy to inform you that filing your insurance claim is not a guarantee of payment. In the event of non-payment, you as the patient/guardian are responsible for the remaining balance. The applicable/responsible party is required to sign this form, which is an assignment of insurance benefits. I understand the responsible party is the person that signs the patient in, not the insurance policy holder.**

By my signature I hereby understand the above statement and will abide by office policy. I also authorize the billing service for Emerald Coast Family Medicine to bill my medical insurance for payment. I am also aware that I am responsible for any balance applied to my deductible or copay not collected at time of service.

Should there be a change in my insurance information, it is my responsibility to inform Emerald Coast Family Medicine of any changes. I understand that my insurance may have a time filing limit. Should I fail to info Emerald Coast Family Medicine of changes in my insurance information in a timely manner, I will be responsible for any and all charges not paid by my insurance.

Patient/Legal Guardian ____ **Date:** _______________

CONTROLLED SUBSTANCE AGREEMENT: By my signature below, I understand that I am NOT here to discuss or to be treated for ANY chronic pain condition. Furthermore I understand that ANY controlled substance will be prescribed at the sole discretion of Dr. Castaneda.

Signature: ____ **Date:**_______________________