Beckman and Associates, Inc.

620 North Wymore Road Suite 230 Maitland, FL 32751 Phone (407) 647-4740 / Fax (407) 647-6415

Patient

Name (Last, First)		Age	Date of Birth	Sex M / F
Mailing Address	City		State	Zip Code
Chief Concerns	Home Phone		Cell Phone	
Email Address				

Mother / Legal Guardian

Name (Last, First)	Date of Birth	Employer		Work Phone
Address (put same if same as above)	City	State	Zip Code	Cell Phone

Father / Legal Guardian

Name (Last, First)	Date of Birth	Employer		Work Phone
Address (put same if same as above)	City	State	Zip Code	Cell Phone

Referring Provider

Name (Last, First)	Phone	Fax

Primary Care Physician / Specialist

Name (Last, First)	Phone	Fax

Primary Insurance Information

Primary Insurance Company	Policy Holder Name		Date of Birth	Co-Insurance %
Insurance Address	City	State	Zip	Co-Pay
Policy Number	Group Number	Phone Number		Deductible

Patient Release

I verify that the information I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies and their agencies, for the purpose of filing and payment of medical claims. I also authorize payment of the medical benefits to the provider. **I agree and acknowledge that I am responsible for all deductible, co-payments, and non-covered services.** I am aware that a fee at the provider's current rate may be charged on all past due balances. If I do not cancel my appointment with 24-hour notice it will result in a service charge of $25.00. I am aware that Beckman and Associates does not file Secondary Insurance Claims.

Signature of insured or authorized person	Date