



# FLORIDA INTEGRATIVE MEDICAL CENTER

2415 University Pkwy, Ste. 218, Sarasota, FL 34243 | (941) 955-6220

## Patient Information Form

Date: \_\_\_\_\_

Legal Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Preferred Name: \_\_\_\_\_

Sex:           F                   M

Mailing Address: \_\_\_\_\_ Unit#: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Known Allergies: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Name of referral, if applicable: \_\_\_\_\_

### Do you have any of the following advance directives in place? (please circle all that apply)

Living Will                   Healthcare Surrogate                   POA/DPOA                   DNR

Please provide copies of any advanced directives you have in place to be added to your chart.

### Emergency Contact

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

### Insurance Information

Insurance Provider: \_\_\_\_\_ Policy #: \_\_\_\_\_

Claims Address: \_\_\_\_\_

Phone: \_\_\_\_\_

“I authorize the release of any medical information necessary for the processing of medical claims related to laboratory services. I understand that Florida Integrative Medical Center is a self-pay practice and does not bill or submit claims to insurance for office services. As a courtesy, certain routine laboratory services may be submitted to insurance; however, I acknowledge that I remain fully responsible for all charges incurred, including any amounts not covered or paid by my insurance or other third-party payers.”

SIGNATURE

PRINT NAME

DATE