MIDWAY SPECIALTY CARE CENTER

Berjan Collin, MD
Moti Ramgopal, MD
Oscar Martinez-Lopez, MD
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1801 SE Hillmoor Dr. Suite #C207
Port St. Lucie, FL 34952
(772) 335-4234 tele
(772) 335-4236 fax

Updated Patient Questionnaire

Personal Information Today's Date: _____

Last Name, First Name, Middle Initial: _____Date of Birth: _____

Preferred Name: _____ Social Security Number: _____

Relationship Status: □ Single □ Sig Other □ Separated □ Married □ Divorced □ Widowed

Home Address: _____City, State and Zip Code: _____
Mailing Address: □ Same as Above
_____ _____City, State and Zip Code: _____

Phone Number(s) □ Home: _____ □ Cell: _____□ Work: _____
Check box representing preferred number for patient reminders, etc.

Email Address: _____ Enable Patient Portal: □ Yes □ No

Emergency Contact: _____ Phone: _____ Relationship: _____

****Name of Primary Care Provider**: _____

Address: _____ City, State and Zip Code: _____

Employment Status: □ Full time □ Part time □ Retired □ Self □None
Student Status: □ Full time □ Part time □None

Employer Name/School Name: _____

Address: _____ City, State and Zip Code: _____

Occupation: _____

Patient Preferred Pharmacy: _____ Phone #: (_____)_____

Insurance Information

Primary Insurance Company: _____ Policy Holder: _____

Policy Number: _____ Group Number: _____

Financial Responsible Party: _____

I hereby consent to Midway Specialty Care Center, Inc .obtaining my **Prescription History** from any/all sources.

Patient's Signature:

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CONSENTS

Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that we ask your permission before disclosing certain healthcare information to certain people or entities.

In accordance with the Act, I _____Hereby authorize Midway Specialty
(Patient signature)
Care Center, Inc. to release any information regarding my health to the following persons or entities:

Name	Date of Birth	Relationship	Phone Number

Leaving Messages for You

In the event that I am not available when Midway Specialty Care Center, Inc. calls with medical information:
*(Please check the applicable box **and** initial beside it.)*

□ _____ Please DO leave messages on my answering machine or voicemail.
□ _____ Please DO NOT leave messages on my answering machine or voicemail.
□ _____ I DO NOT HAVE an answering machine or voicemail.

Insurance Authorization and Assignment

All Charges are payable at the time of service.

All professional services rendered are charged to the patient. Necessary forms will be complete to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage; it is also customary to pay for services when rendered unless other arrangements have been made in advance.

Insurance Authorization and Assignment: I hereby authorize Midway Specialty Care Center, Inc. to furnish information to insurance carriers concerning my illness and treatments and I hereby assign all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by my insurance.

Furthermore, I am aware that if I have an HMO Plan a referral must be obtained from my primary care provider for EACH visit to Midway Specialty Care Center. If one is NOT obtained, I understand that I will be held responsible for all charges.

Printed Name: _____

□ Self or Relationship to Patient: _____

Signature: _____ Date:_____