

### Encounter Form

Please print or verify information: Referred by: \_\_\_\_\_

Patient's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I.: \_\_\_\_\_

Street Address: \_\_\_\_\_

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

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

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Marital Status: (Circle One)    Single    Married    Separated    Divorced    Widowed

Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

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

Employer Name: \_\_\_\_\_ Emp Address: \_\_\_\_\_

**PRIMARY** Insurance Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Street: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_ Payer Number: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

**SECONDARY** Insurance Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Street: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_ Payer Number: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

All charges are due at the time of service unless other financial arrangements have been made. The patient remains responsible for all fees regardless of insurance coverage. I hereby authorize Jack G. Faup, M.D. to release any and all medical information to the insurance company to process insurance claims on my behalf.

I hereby authorize assignment of insurance benefits to be paid directly to Jack G. Faup, M.D. for services provided. I agree to be responsible for any deductibles, co-payments and other fees as determined by my insurance company. I certify this information is true and correct to the best of my knowledge.

**Under Florida law, physicians are generally required by law to carry malpractice insurance and otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. Jack Faup, M.D. has decided not to carry medical malpractice insurance.**

I permit a copy of this release to be used in place of the original.

\_\_\_\_\_  
Patient/Insured's Signature

\_\_\_\_\_  
Date