

Robert Ashmore, M.D.
A.J. Brickler III, M.D.
Arthur Clements, M.D., Ph.D.
David Dixon, D.O.
Alex S. Franz, M.D.
Andrea K. Friall, M.D.



Kenneth McAlpine, M.D.
Vikki McKinnie, M.D.
David O'Bryan, M.D.
Lori W. Rosenberg, M.D.
Terrie Tullos, A.R.N.P.-C.

1401 Centerville Road, Suite 202 • Tallahassee, FL 32308-4638 • (850) 877-7241

Patient Registration

Patients's Name: Last Name _____ First Name _____ Middle Initial _____

Home Address _____ Apt # _____

City _____ State _____ Zip _____ Date of Birth _____ Age _____

Permanent Address (if Different From Above) _____

City _____ State _____ Zip _____

Marital Status _____

Home Phone (____) _____ Cell Phone (____) _____ Drivers License _____

E-mail Address _____

Social Security # _____ Patient's Employer _____

Occupation _____ Work Phone (____) _____ Ext _____

Student? _____ Where? _____ Status _____

Referring Physician _____

Spouse / Partner's Name _____ Employer _____

Occupation _____ Work Phone (____) _____ Ext _____

Policy Holder: _____ (Complete the rest of this box only if the policy is under another name)
Last Name _____ First Name _____ Middle _____
Address _____ City _____ State _____ Zip _____
Phone (____) _____ SS# _____ DOB _____

Person who does not live with you that we can contact in case of an emergency:

Name _____ Phone (____) _____ Relationship _____

How did you hear about us?

COMPLETE OR ATTACH A PHOTOCOPY OF INSURANCE CARD

Insurance Co. #1 _____ Insured # _____

Claims Address _____ State _____ Zip _____

Insured Name _____

Insurance Co. #1 _____ Insured # _____

Claims Address _____ State _____ Zip _____

Insured Name _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby assign all payments for services rendered to me or my dependents to North Florida Women's Care. This assignment is considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information to insurance carriers concerning my illness and treatment.

SIGNED (Insured or Authorized Person) _____ Date _____