CFP PHYSICIANS GROUP

PATIENT INFORMATION

Name:	Primary Phone #:
Address One:	Email:
Address Two:	Social Security #:
City:	Date of Birth:
State: FL Zip:	Employer:
Home Phone#:	Emergency Contact:
Work Phone#:	Emergency Phone#:
Cell Phone#:	Emergency Relationship:
Communication Preference (circle one) : Mail Phone Other	

GUARANTOR/POA/PARENT (Financial Responsibility)

Name:	Date of Birth:
Address One:	Social Security#:
Address Two:	Home Phone#:
City:	Work Phone#:
State: FL Zip:	Cell Phone#:
	Employer:

INSURANCE INFORMATION

Primary Insurance:	Secondary Insurance:
Certificate#:	Certificate#:
Group Number:	Group Number:
Group Name:	Group Name:
Copay:	Copay:
Subscriber Name:	Subscriber Name:
Subscriber DOB:	Subscriber DOB:

MEANINGFUL USE

RACE:	LANGUAGE:
ETHNICITY:	SEX:

Financial Policy: Payment for co-payments, deductibles and coinsurance are expected at the time services are rendered. Any necessary financial arrangements are to be made prior to treatment. We bill only insurances we are contracted with and the patient is expected to know what coverage they have.

The above information is accurate to the best of my knowledge.

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Signature (patient or parent if minor) Date