PATIENT INFORMATION

Flagel Pediatric & Family Medicine
2560 Commerce Parkway
North Port, Florida 34289

David A. Flagel, M.D.
Board Certified, Family Medicine
Susan D. Flagel, D.O.
Board Certified, Pediatrics

Patient's Name: _________________________ Birthdate: ________Gender: ___ Date: __________

Alternate/Nickname: ______________________ Soc. Sec. No. ________________________________

Address: ____ Phone: ___________________

Email Address: ____

Family members Information:

Name: ______________________ DOB: ______________ Soc. Sec. No. ___________________

Name: ______________________ DOB: ______________ Soc. Sec. No. ___________________

Name: ______________________ DOB: ______________ Soc. Sec. No. ___________________

Name: ______________________ DOB: ______________ Soc. Sec. No. ___________________

Caregiver/Parent/Guardian:

Name: ____

Date of Birth: _______________ Gender: ____ Soc. Sec. No. ____________________________

Marital Status: ______________________ Spouse's Name: ______________________________

Employer: __________________________ Work Phone: ________________________________

Relationship to Patient: ____

Other Info:

How did you hear about us? ____

Should anyone else have access to billing statements or medical records? Yes ____ No ____

Please list such individuals: ____

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INSURANCE INFORMATION: Please give us all pertinent information regarding your insurance coverage and present a copy of your card to our receptionist.

Primary Insurance Company: ____

Primary policy holder: ________________________________ Birthdate: __________

Address of policy holder: ____

Relationship to patient: ____

ID Number: ____________________Group Number: ________________________

Effective date: ____

Secondary Insurance Company: ____

Primary policy holder: ________________________________ Birthdate: __________

Address of policy holder: ____

Relationship to patient: ____

ID Number: ____________________Group Number: ________________________

Effective date: ____

I verify that this information is correct and that I am ultimately financially responsible for any charges incurred. I authorize the release of any medical or other information necessary to process this claim. I also request payment of benefits either to myself or to the party who accepts assignment.

Signature: ______________________________ Date: ______________________________