D O C C S

Diagnostic & Clinical Care Services

2100 N. Wickham Rd., Melbourne, FL 32935
Ph: 321.259.6007 Fax: 321.752.7105

PATIENT DEMOGRAPHICS

PATIENT NAME	DOB	SS#
STREET ADDRESS	PHONE *(H)* *(C)*	
CITY	STATE	ZIP
SEX **(M) (F)**	MARITAL STATUS **(M) (S) (D) (W)**	EMAIL ADDRESS

(IF MINOR) GUARDIAN NAME	RELATIONSHIP TO PATIENT
STREET ADDRESS	WORK PHONE
CITY	STATE ZIP
DOB SS#	EMAIL ADDRESS

SPOUSE NAME	SPOUSE EMPLOYER
SPOUSE DOB	SPOUSE SS#

HOW DID YOU HEAR ABOUT US?

REFERRING PROVIDER:

REASON FOR TODAY'S VISIT:

SYMPTOMS (CHECK ALL THAT APPLY):

	FEVER		CHILLS
	EYE PAIN		LOSS OF VISION
	EAR PAIN		SORE THROAT
	COUGH		BREATHING DIFFICULTY
	CHEST PAIN/PRESSURE		IRREGULAR HEART BEAT
	STOMACH PAIN		VOMITING
	PAINFUL URINATION		FREQUENT URINATION
	JOINT SWELLING		MUSCLE/JOINT PAIN
	EXCESSIVE THIRST		WEIGHT CHANGE
	ABNORMAL BLEEDING		EASY BRUSING
	RASH		ITCHING
	HEADACHE		ARM/LEG WEAKNEDD
	DEPRESSION		ANXIETY

OTHER:

CIRCLE ALL THAT APPLY

ARE YOU PREGNANT? **(Y) (N)**	DO YOU SMOKE? **(Y) (N)**	DO YOU DRINK? **(Y) (N)**

FAMILY HISTORY OF:

HEART DISEASE STROKE DIABETES CANCER OTHER:

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PRIMARY INSURANCE

MEMBER ID	GROUP ID

SECONDARY INSURANCE

MEMBER ID	GROUP ID

EMERGENCY CONTACT

NAME	RELATIONSHIP	PHONE
NAME	RELATIONSHIP	PHONE

AUTHORIZATION AND ASSIGNMENT OF BENEFITS FOR COMMERCIAL INSURANCE SERVICES

I authorize release of any information necessary to secure the payment of insurance benefits for services I receive to diagnostic and Clinical Care Services, all insurance benefits payable for the medical services rendered by physicians or staff. I authorize the use of this signature on all insurance submissions.

_____ _____

SIGNATURE *DATE*

AUTHORIZATION AND ASSIGNMENT OF BENEFITS FOR MEDICARE SERVICES

I request that payment of authorized Medicare benefits be made to Diagnostic and Clinical Care Services for any services furnished to me by physicians and staff. I authorize any holder of medical information about me to release to the Healthy Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for needed services. My signature below requests that payment be made and authorizes release of medical information necessary to pay the claim. If I have insurance that is a supplement to Medicare, my signature authorizes release of information to such insurer or agent for the purpose of paying Diagnostic and Clinical Care Services any benefits payable by such insurance.

_____ _____

SIGNATURE *DATE*