Dr. George Elias, DO & Dr. Theresa Oakley, DO
63 East Third Street Apopka, FL 32703
www.apopkafamilydoctors.com

ADULT PATIENT INFORMATION: Please write clearly.

Last Name: ______________________ First Name: ______________________ MI: ______

Mailing Address: ______________________ City: ______________________

State ______ Zip ______ Sex: M or F Date of Birth: ______________ Age: ______

Home Phone #: ______________ Cell #: ______________ Work/other # ______________

Which is the best phone number to reach you and/or leave a message? ☐ Home ☐ Cell ☐ Work

SSN: ______ - ______ - ______ Marital Status : M S W D

Home Address (if different from mailing address) ______________________ City: ______________

State ______ Zip ______ Email address: ______________________

Can we email you information from our office?______ including appointment reminders?______including general newsletters?______

Occupation: ______________________ Employer Name: ______________________

Employer Address: ______________ City: ______________ State: ______ Zip: ______

Spouse Name: ______________________ Spouse Employer: ______________________

Please check the appropriate box:

Race: ☐ White ☐ Black or African American ☐ Hispanic ☐ Asian ☐ American Indian or Alaska Native ☐ decline to answer

Ethnicity: ☐ Hispanic or Latin ☐ Not Hispanic or Latin ☐ decline to answer

Primary Language: ☐ English ☐ Spanish ☐ Other: ______________

Please provide insurance card and drivers license to receptionist. Please notify us of any changes in your insurance information. COPAY AND DEDUCTIBLES ARE DUE AT TIME OF SERVICE.

Policy Holder's Name : ______________________ Relationship to Patient ______________

Policy Holder's SS# ______ - ______ - ______ Policy Holder's Date of Birth ______________

Policy Holder's Employee Address: ______________________

Policy Holder's Home Phone Number ______________ Policy Holder's Work Phone Number ______________

Please provide contact information for nearest living relative, not in your household, that we may contact in case of emergency.

Name: ______________________ Relationship: ______________ ______________

Phone: ______________ Alternate Phone Number: ______________________

Address: ______________________ City: ______________ State ______ Zip ______________

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Page 2 Adult Information

How did you hear about us?

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Advanced Directive: All adults in health care settings have the right in the state of Florida to an "advanced directive". This is a written or oral statement made and witnessed in case of a serious illness or injury, stating how medical decisions will be made for you. An advanced directive enables you to state your decisions, or may name someone to make decisions for you, if you should become unable to make decisions about your own medical treatment. In signing this statement, you understand that information is available to you on advanced directives. Please ask us for more information or go to www.floridahealthfinder.gov.

SIGNATURE: ____**DATE:**__________________

At times, we may need to view your previous prescriptions so that we may care for you to the best of our abilities. By signing this, you grant Drs. Elias & Oakley, permission to view prescription history from external sources.

SIGNATURE: ____**DATE:**__________________

I authorize the release of any medical information necessary to obtain payment of medical benefits from my health insurance company. I authorize my insurance company to pay Drs Elias & Oakley, PA any medical benefits due for their services. I understand that I am responsible to pay deductibles, copays and any other charges not paid by my insurance company.

Our policy is that payment is expected in full at time of service, unless other financial arrangements are made in advance. If you participate with one of our contracted insurance programs, we will bill your insurance company, initially, for services rendered. You are responsible for repeated filings of insurance or filing to secondary insurance. **Co-payments and deductibles are due at time of your office visit**. There is a $30.00 return check fee. If your account becomes delinquent, you are responsible for your bill plus all collection costs. Please read our additional office policy form for further information regarding payment policies.

You are responsible for notifying us of any changes in your insurance information, billing address, phone numbers.

You may request a copy of our Notice of Privacy Practices in accordance with HIPPA law. If you would like significant others to receive personal medical information about you, it is necessary to complete a Disclosure Form.

To the best of my knowledge the above information is correct. I understand and agree to comply with Drs. Elias & Oakley, PA financial policies.

SIGNATURE: ____ **DATE**: __________________

PRINT NAME: ____