

RIDGE MEDICAL ASSOCIATES, LLC
405 South 11th Street, Lake Wales, FL 33853
2209 North Blvd. West, Suite A, Davenport, FL 33837

Please complete this form and return to the receptionist

PATIENT INFORMATION

Patient's Name _____ Age _____ Date of Birth _____

Patient's Social Security Number _____ Drivers License # _____ State _____

Responsible Party (If Minor) Father _____ Mother _____

Mailing Address: _____ City _____ State _____ Zip _____

Street Address: _____ City _____ State _____ Zip _____

Out of State Address: _____ City _____ State _____ Zip _____

Home Phone: (_____) _____ Home Phone: (_____) _____
(Local) (Out of State)

Cell Phone: (_____) _____ Work Phone: (_____) _____

Email address: _____

Sex: _____ Height _____ Weight _____ Race: _____ Married _____ Single: _____

Employer: _____

Address: _____ City: _____ State _____ Zip _____

Spouse's Name: _____ Spouse's Social Security #: _____ Spouse's DOB: _____

Spouse's Employer: _____ Employer's Address: _____ Employer's Phone: _____

Nearest Relative: _____ Relationship _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Patient Referred by: _____ Family Physician: _____

ASSIGNMENT OF INSURANCE BENEFITS AND FINANCIAL AGREEMENT

I hereby authorize direct payment of medical/surgical benefits to Ridge Medical Associates, LLC for services rendered by the provider in person or under his supervision. I understand that I am responsible for any balance not covered by my insurance and agree to pay the balance due in full upon receipt of the invoice from Ridge Medical Associates, LLC. If payment is not made, I understand that Ridge Medical Associates, LLC will pursue its normal collection policy.

AUTHORIZATION TO RELEASE INFORMATION

I authorize Ridge Medical Associates, LLC, to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefits, including information on drug use, alcoholism and HIV test results.

MEDICARE-MEDICAID-MEDIGAP

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.
A photocopy of these assignments shall be as valid as the original.

PATIENT/GUARANTOR SIGNATURE _____ **DATE** _____