Maguire Family Medicine – Amy Jackson, DO & Suvy Kuriakose, MD
2731 Maguire Road
Ocoee, FL 34761
p 407.877.1990
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Thank you for choosing Maguire Family Medicine; in order to better serve you, **please print, complete and bring to your appointment** the following information:

**PATIENT NAME:** Last _____ First _____MI_____

**ADDRESS:** _____ City_____ State_____ Zip_____

**Home Phone:** _____W**ork Phone:** _____**Cell**: _____

Email address: _____ (We will not release patient information via email)

**SEX: __M__F DOB: _____/_____/_____ AGE____ MARITAL STATUS: ___Single ___ Married ___ Divorced ___ Widowed**

**PATIENT SS#: _____/_____/_____**

**OCCUPATION**_____ **Employer**_____

Spouse Name: _____ Spouse occupation_____

Spouse Employer: _____ Spouse Phone # _____

**INSURANCE INFORMATION -** PLEASE PROVIDE INSURANCE CARD & DRIVER'S LICENSE
Policy Holder: _____ Relationship to Patient: _____Insured DOB: _____/_____/_____
Insured's SS#: _____/_____ /_____ Name of insurance: _____

**SECONDARY INS. INFO:** Insured _____ DOB: _____/_____/_____

**NEAREST RELATIVE NOT LIVING WITH YOU (emergency contact)**
**Emergency contact name: _____Relationship_____Phone_____**
Address_____ City_____ State _____ Zip_____

Can we call you at work with appointment information or test results? (Circle one) YES NO
Can we leave messages on voice mail or mail health related information to you from our office? (Circle one) YES NO

HOW DID YOU HEAR ABOUR OUR OFFICE? _____

**TO WHOM DO YOU AUTHORIZE MAGUIRE FAMILY MEDICINE TO RELEASE MEDICAL INFORMATION?**

Name: _____ Relationship: _____

Patient Signature: _____ Date: _____

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 advanced of a serious illness or injury. An advanced directive enables you to state your choice, or may name some one to make your choice for you, if you should become unable to make decisions about your medical treatment. **I have received information on an advanced directive: _____ Yes _____ NO Date: _____ _____ Initial**

I consent to treatment and authorize the release of protected health information (PHI) necessary for treatment and obtaining payment of medical benefits from my health insurance company. I authorize my insurance company to pay Maguire Family Medicine/West Orange Physicians Group, LLC any medical benefits due me for their services. I understand I am responsible to pay deductibles, co-pays and other charges not paid by my insurance company. Our policy is that payment is expected in full at time services are rendered, unless other financial arrangements are made in advance. If you participate with one of our contracted insurance programs, we will bill your insurance. CO-PAYMENTS AND DEDUCTIBLES ARE DUE AT THE TIME OF YOUR OFFICE VISIT. Therefore, verification of your insurance, deductible, and co-payment in advance of your office visit will be necessary.

A copy of Orlando Health's Notice of Privacy Practices is available to me for review at my request.

**Signature: _____**

**Print Name: _____ Date_____**