Stoneybrook Family Medicine Group
16106 Marsh Road, Suite 102
Winter Garden, FL 34787
p 407.347.0600
f 407.347.0599

Thank you for choosing Stoneybrook Family Medicine Group; 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 STONEYBROOK FAMILY MEDICINE GROUP 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 Stoneybrook Family Medicine Group/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_____