

# FLORIDA INSTITUTE OF NEUROSCIENCE

## PATIENT INFORMATION

(Please print)

Patient's Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ DOB: \_\_\_\_\_

Sex:  Female  Male  Transgender

Race:  American Indian/Alaska Native  Asian  Native Hawaiian/Pacific Islander

Black/African American  White  Hispanic  Other  Declined

Language:  English  Spanish  Indian: Hindi, etc.  Japanese  Chinese  Korean  French  German  Russian  Other

Ethnicity:  Hispanic or Latino  Not Hispanic or Latino  Declined

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

## RESPONSIBLE PARTY INFORMATION (If not self)

(Information used for patient balance statements)

Responsible party:  Another patient  Guarantor  Self Check here if address and telephone information is same as patient

Responsible party name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_

Date of birth: MM \_\_\_\_ / DD \_\_\_\_ / YYYY \_\_\_\_

Sex:  Female  Male

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Phone number: \_\_\_\_\_

Address: \_\_\_\_\_

City, State: \_\_\_\_\_ ZIP: \_\_\_\_\_

**INSURANCE INFORMATION:** Provide your insurance card(s) (primary, secondary, etc.) to the front desk at check-in.

## EMERGENCY CONTACT INFORMATION

Emergency contact name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_

Phone number: \_\_\_\_\_ Do you have a living will?  Yes  No

Emergency contact relationship to patient: \_\_\_\_\_  Guardian

Address: \_\_\_\_\_

City, State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_ Ext. \_\_\_\_\_

## GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

**TO THE PATIENT:** You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of patient or personal representative: \_\_\_\_\_ Date: \_\_\_\_\_

Printed name of patient or personal representative: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_