

Trinity Family Physicians



Let Our Family Care for Yours

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Trinity, FL 34655

Phone: (727) 834 - 8377

Fax: (727) 834 - 8371

Name: _____ D.O.B: _____

Social Security #: _____ Email Address: _____

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

Employer: _____ Occupation: _____

Home Phone: _____ Leave Message: Yes / No (call order _____)

Cell Phone: _____ Leave Message: Yes / No (call order _____)

Work Phone/ext: _____ Leave Message: Yes / No (call order _____)

Emergency Contact Name: _____ Relationship: _____

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

Home Phone: _____ Cell Phone: _____

Circle one for each category:

Do you reside in FL year round? Yes / No (If no, please fill in the following section)

Do you have an alternative PCP that takes care of your routine/yearly care? Yes / No

Alternative PCP Name: _____ Phone: _____

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

Months at the alternative Address: _____ to _____

Circle one for each category:

Sex: M / F Employment Status: FT / PT / Retired/Other Student Status: FT / PT

Marital Status: Married / Single / Divorced / Widowed / Legally Separated / Significant Other

Preferred Language: English / Spanish / Russian / Indian / Other

Ethnicity: Hispanic / Non-Hispanic

Race: Caucasian / African American / Hispanic / American Indian / Asian / Hawaiian / Other

Primary Insurance: _____ Insured's Name: _____

Social Security #: _____ D.O.B: _____ Relationship: _____

Policy / Subscriber #: _____ Group #: _____

Eligibility / Customer Service Phone: _____

Secondary Insurance: _____ Insured's Name: _____

Social Security #: _____ D.O.B: _____ Relationship: _____

Policy / Subscriber #: _____ Group #: _____

Eligibility / Customer Service Phone: _____

Local Pharmacy: _____ Address: _____ Phone: _____

Mail Order Pharmacy: _____ Address: _____ Phone: _____

Insurance Assignment & Release Form: I hereby authorize my Insurance Benefits to be paid directly to Trinity Family Physicians. I also authorize the physician to release any information required and/or requested by my insurance carrier.

Signature: _____ Date: _____

Co-Pay or Payment is due upon the day services are rendered. Cash, Check, Visa, MasterCard, Discover or American Express