Trinity Family Physicians

Let Our Family Care for Yours

Amir Shirmohammad, MD, MPH Stephanie Eldridge, MD, MPH

1817 Cypress Brook Drive, Suite 101
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