St. Petersburg
LIMB & BRACE
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1001 37th St. N
Suite B
St. Petersburg, FL 33713
727-321-3900
www.stpetelimbandbrace.com

# PATIENT INFORMATION RECORD

## Page 2

Other Insurance Company: _____ Phone _____

Street Address _____ Apt #____ City _____ State ____ Zip _____

ID#_____ Policy #_____ Group#_____

Policy Holder's Name_____ Date of Birth ____/____/____

Policy Holder's Address (if other than patient's): Phone_____ Relationship to Patient _____

Street Address _____ Apt #____ City _____ State ____ Zip _____

Policy Holder's Employer (if other than patient's): _____ Phone _____

Street Address _____ Suite ____ City _____ State ____ Zip _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS I authorize payments of medical benefits to the provider for services, rendered or to be rendered in the future, without obtaining my signature on each claim submitted, and the signature will bind me as though I personally signed the claim. I also authorize the release of any medical information necessary. I UNDERSTAND I AM RESPONSIBLE FOR ALL CHARGES. If this account should be referred to a collection agency, I will be responsible for any collection and/or legal fees. I have read and understand the office policy and procedures.

_____ _____ _____

Responsible Party Signature | Relationship | Date