Adam S. Plotkin, M.D., P.A. • Ross N. Clark, M.D. • Ronnit H. Stein, M.D. • Kathleen Herne, M.D. • Jacob D. Kalmanson, M.D.

Name:_____ Male/Female_____ Birthdate:_____ Age:_____

Florida Address:_____
Street Address City State Zip

Phone:_____ Cell:_____ Email:_____

Alternate Address:_____ Alternate Phone:_____

Marital Status: Single_____ Married_____ Divorced_____ Separated_____ Widow(er)_____

Social Security Number:_____

Employer:_____ Employer Phone:_____ Ext._____

Employer Address:_____

Spouse:_____ Spouse Birthdate:_____

Spouse Social Security Number:_____

Spouse Employer:_____ Spouse Employer Phone:_____

If other than patient is responsible for payment: (This does not include insurance company)

Name:_____ Phone:_____

Address:_____ Birthdate:_____

Relationship to patient:_____ Social Security Number:_____

Insurance is a contract between you and your insurance company. In MOST cases, we are NOT a party to this contract. We will not become involved in disputes between you and your insurance company regarding deductible, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc. other than to supply factual information as neccesary. You are responsible for the timely payment of your account. Any account 90 days or more past due will incur reasonable collection and/or attorney fees. In addition, any account 90 days or more past due will be charged 1 1/2 interest a month from the date of service.

Primary Insurance Co.:_____ ID#_____

Secondary Insurance Co.:_____ ID#_____

Family Doctor:_____ Doctor's Phone:_____

Referred By:_____

How did you hear about our office: ❑ Doctor's Office_____ ❑ Friend_____ ❑ Health Fair_____

❑ Newspaper_____ ❑ Yellow Pages_____ ❑ Community Flyer_____

Pharmacy Name:_____ Pharmacy Phone Number:_____

❑ I will allow messages to be left on my ❑ Cell Phone ❑ Home Phone ❑ Email regarding office appointment
❑ I will allow messages to be left on my ❑ Cell Phone ❑ Home Phone ❑ Email regarding information relating to my care.
❑ I will allow my health information to be discussed
with_____

By signing, I am acknowledging that I have disclosed all of my health information known to me at this time, and all of my other personal information is adequate. I agree not to post online information that can cause damage to the practice.

Signature:_____ Date:_____