

Hughston Clinic/Hughston Medical

Hughston Lake Nona
6775 Chopra Terrace
Orlando, FL 32827
Ph: (407) 965-4114
Fax: (833) 408-2573

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PATIENT INFORMATION

Patient Name:	Birthdate:	SSN:	Marital Status:	Account #
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Age:	Sex:	Race:	Email:	Cell Phone:
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Address:	Work Phone:	Home Phone:
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Employer:	Employer Address:	Employer Phone:
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Emergency Contact Name:	Emergency Contact Phone:	Relationship:
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Guarantor Name:	Guarantor Address:	Guarantor SSN:
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Referring Provider:	Primary Care Physician Name:	Phone #:
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Primary Insurance Name:	Name of Insured:	Certificate Number:
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Group Number:	Policy Number:	Insured's DOB:
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Secondary Insurance Name:	Name of Insured:	Certificate Number:
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Group Number:	Policy Number:	Insured's DOB:
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Workers Comp Injury Date:	Workers Comp Employer:	Workers Comp Employer Phone:
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Workers Comp Employer Address:	WC Contact Person:
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Consent For Treatment / Medication History Authorization

I authorize Hughston to perform treatment deemed by the physician in exercise of professional judgement to be of appropriate kind and method on me / my dependent. I hereby authorize The Hughston to release any information acquired in my examination or treatment to any insuror, government agency providing benefits, or to anyone for charges. I understand my prescriptions will be transmitted electronically via SureScripts, a Pharmacy Benefits Manager and authorize Hughston access to my prescription history.

SIGNED _____ DATE _____

Insurance Assignment

I hereby assign to and authorize payment to Hughston of all benefits payable under the terms of any insurance policy listed above. I realize the insurance, workman's compensation, and/or liability claims may not pay all of the bill. I agree to pay the difference or the entire bill if necessary. I also agree to pay costs of collection, including attorney's fee and waive my exemption under the constitution and laws of the states of Alabama, Florida, Georgia, Indiana, and Tennessee.

SIGNED _____ DATE _____