ORLANDO PSYCHIATRIC ASSOCIATES

ORLANDO: 2345 SAND LAKE ROAD, SUITE 200.
ORLANDO, FL 32809.
TEL: (407) 851-5121, FAX: (407) 851-0439

OCOEE:1551 BOREN DR. UNIT B. OCOEE, FL 34761
TEL: (407) 532-4940, FAX: (407) 532-4946

REGISTRATION INFORMATION

(PLEASE PRINT)

Home Phone_____

Patient Name _____
Last First Mi

Sex ☐ M ☐ F Age_____ DOB_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Street Address_____
City_____ State_____ Zip_____

☐ Employed ☐ Full-Time Student ☐ Part Time Student Patient's School Name_____

Responsible Party (if a minor) _____

Employed By_____

Business Address _____

Occupation_____ Business Phone_____

Spouse (or responsible party) Name_____ Date of Birth_____

Business Name and Address _____

Occupation_____ Business Phone_____

Who is responsible for this account? _____ Relationship to Patient_____
Social Security # _____ Spouse's Social Security #_____
Do you have Medical Insurance? ☐ No ☐ Yes If yes,
Name of Primary Insurer_____

Contact #_____ Group #_____ Subscriber #_____
Name of Secondary Insurer (if any) _____
Contact #_____ Group #_____ Subscriber #_____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____
(Name of Insurance Company)
and assign directly to Orlando Psychiatric Associates all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____ _____
Signature of Insured/Guardian Date