

**Infectious Diseases  
Associates** □ □ □  
OF NORTH CENTRAL FLORIDA

Tel: (352) 622-2020  
Fax: (352) 622-2025  
3306 SW 26th Ave. #104  
Ocala, Florida 34471  
www.IDocala.com

**PATIENT INFORMATION**

*Please answer all questions to the best of your ability. PLEASE, do not leave any blanks.*

LAST NAME \_\_\_\_\_ FIRST \_\_\_\_\_ MI \_\_\_\_\_

SSN# \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

ADDRESS \_\_\_\_\_  
*Street City State Zip*

PHONE# \_\_\_\_\_ CELL# \_\_\_\_\_

EMAIL: \_\_\_\_\_

MARITAL STATUS: S M W D Other SEX: M F

PRIMARY LANGUAGE \_\_\_\_\_

RACE \_\_\_\_\_ HISPANIC/LATINO \_\_\_\_\_ NON HISPANIC/LATINO \_\_\_\_\_

SPOUSES NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

PRIMARY PHYSICIAN \_\_\_\_\_

REFERRING PHYSICIAN \_\_\_\_\_

EMPLOYER \_\_\_\_\_ PHONE# \_\_\_\_\_

EMPLOYER ADDRESS \_\_\_\_\_  
*Street City State Zip*

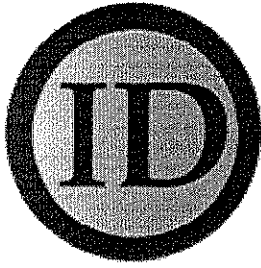
**A PERSON WHO DOES NOT LIVE WITH YOU IN CASE OF AN EMERGENCY**

NAME \_\_\_\_\_ PHONE# \_\_\_\_\_

INSURANCE 1 \_\_\_\_\_ Policy# \_\_\_\_\_

INSURANCE 2 \_\_\_\_\_ Policy# \_\_\_\_\_

DO YOU HAVE A COPAY? YES NO WHAT IS THE COPAY? \$ \_\_\_\_\_



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**ASSIGNMENT OF BENEFITS FORM**

Name of Insured: \_\_\_\_\_

I hereby assign all medical benefits to which I am entitled to "Infectious Diseases Associates of North Central Florida, LLC".

This applies for all insurance carriers, including Medicare, private insurance, and any other health/medical plan. This form will be kept on file.

I understand that it is my responsibility to report any changes in insurance coverage.

I authorize the release of any medical or pertinent information necessary to obtain these benefits to my insurance carrier, or any other medical entity for continued medical care.

I understand that I am financially responsible for any amount not covered by insurance.

*(Note: On any balance on your account after 90 days, including those that insurance has not paid, collection action will be taken. We realize that emergencies do arise and may affect timely payment of your account. If such extreme cases do occur, please contact us promptly for assistance in the management of your account.)*

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**HIPAA**

On April 14, 2003, the state of Florida passes a Patient Privacy Act. The paperwork that we are asking you to fill out is a federal law and must be in all patient charts. If you would like to designate someone to have access to your medical records for any reason, such as appointments, test results, picking up prescriptions, or having any other information on your chart, please let us know and we will have you fill out a form for that.

**Notice of Privacy Act Acknowledgement**

I acknowledge that the notice of privacy practices has been given or made available to me upon request by 'Infectious Diseases Associates of North Central Florida, LLC'.

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_