Ocala Health
Heart & Lung Surgery

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Thank you for allowing Ocala Health Heart & Lung Surgery to participate in your medical care. We are enclosing a *New Patient Information Packet, HIPAA Consent & Acknowledgement, Release of Information, Financial Communication and a Medical History* questionnaire. Please complete these forms & bring the forms to your appointment. If you would like, the completed forms may be faxed to us directly at (352) 629-1406.

For your appointment please arrive 15 minutes early & bring the following:

~ The completed enclosed forms
~ Driver's license
~ Insurance card
~ Any medical records, ***including disks or imaging that you might have from a previous doctor***
~ The names and telephone numbers for present and/or past providers involved in your medical care
~ Actual prescription bottles of all medications including any over the counter medications, vitamins and herbal supplements. If bottles are not available, please bring a list of these medications including dosage and time medication is taken.

If you have any questions or require additional information please contact our office at (352) 629-1378 prior to your appointment. Thank you for taking the time to prepare for your visit and we look forward to seeing you at the time of your appointment.

Sincerely,

Brooke Wilkerson
Practice Manager

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PLEASE PRINT CLEARLY

DATE _____

WHO IS YOUR PRIMARY DOCTOR? _____

PATIENT NAME_____ DOB_____/_____/_____ AGE_____ SEX_____

PHONE ( )_____SS# _____

ALT. PHONE ( ) _____ CELL HOME WORK

PERMANENT ADDRESS_____CITY_____ STATE_____ ZIP_____

LOCAL ADDRESS_____ CITY_____ STATE FL ZIP_____

EMAIL_____ MARITAL STATUS: ____MARRIED ____SINGLE ____OTHER

RACE _____ ETHNICITY: _____HISPANIC OR LATIN_____NOT HISPANIC OR LATIN

EMPLOYED (PLEASE LIST EMPLOYER)_____ PHONE # (_____) _____

IF UNDER 18, MOTHER'S NAME_____SSN_____DOB_____PHONE(____)_____

IF UNDER 18, FATHER'S NAME_____SSN_____DOB_____PHONE(_____)_____

NAME OF SCHOOL_____ _____FULL-TIME STUDENT _____PART-TIME STUDENT

SPOUSE'S NAME_____PLACE OF EMPLOYMENT _____

PHARMACY NAME _____PH # ( ) _____

INSURANCE NAME_____

POLICY NUMBER_____GROUP NUMBER_____

INSURED'S NAME _____INSURED'S EMPLOYER_____

ADDRESS ON INSURANCE CARD_____

PHONE NUMBER FOR ELIGIBILITY ON BACK OF INSURANCE CARD_____

DO YOU HAVE A LIVING WILL / ADVANCED DIRECTIVE
(Circle One)
YES NO

In case of emergency please notify (Someone who does not live in your home) Relationship _____

Name_____ PHONE _____

ADDRESS _____
