CYPRESS
MEDICAL CENTER

131 Webb Drive, Suite C
Davenport, FL. 33837

Patient Information Form

Name: _____

Home phone ( ) _____ Work ( ) _____ Cell ( ) _____

Address _____
City _____ State _____ Zip _____
Sex M__ F__ Birth date ___/__/____ SS# ___-__-____
Marital Status: S __ M __ W __ D __
Email _____

Guarantor: Responsible Party if Not You.

Name: _____

Home phone ( ) _____ Work ( ) _____ Cell ( ) _____
Address _____
City _____ State _____ Zip _____
Sex M__ F__ Birth date ___/__/____ SS# ___-__-____
Relationship to You _____

Emergency Contact:

Name of nearest relative, not living with you. _____
Address _____
City _____ State _____ Zip _____ Phone ( )_____
Relationship to you _____
Name of person to call in case of emergency _____
Address _____
City _____ State _____ Zip _____ Phone ( )_____
Relationship to you _____

Insurance Information:

Primary Insurance Co. _____
Policy Holder _____ DOB ___/__/_____
Co-pay _____ Is a Pre-cert required for IN or OUT patient services? _____
Policy# _____ Group# _____ Date Effective _____
Secondary Insurance Co. _____ SS#_____
Policy Holder _____ DOB ___/__/_____
Co-pay _____ Is a Pre-cert required for IN or OUT patient services? _____
Policy# _____ Group# _____ Date Effective _____

I hereby provide consent for Dr. Raphael Lopez, LLC to release my protected health information for payment. Additionally, I request that payment of authorized insurance benefits (including Medicare benefits, if applicable) be made on my behalf to Dr. Raphael Lopez, LLC for any services furnished to me by Dr. Raphael Lopez, LLC. I authorize Dr. Raphael Lopez, LLC to release medical information about me to my Insurance Carrier and/or Center for Medicare and Medicaid Services, if applicable, and it's agents to the extent necessary or desirable to determine these benefits or benefits payable for related services. The above patient information is complete and correct. I authorize treatment for the above patient. In the event of collection proceedings due to lack of payment on my part, I agree to pay any and all collection fees that may be added to my account in order to recover monies due to the doctor.

X _____ Date: _____
(Patient/Parent/Guardian Signature)