TRINITY
DOCTORS GROUP, PA

Patient Last Name _____ First Name_____M.I. _____

Primary Address: _____City _____ State & Zip _____

Secondary Address: _____City _____ State & Zip _____

Home Phone (____) _____ Cell Phone (____) _____Work Phone (___) _____

Social Security_____-_____-_____ DOB: _____/_____/_____ Age_____ Gender: M ( ) F ( )

Employer _____ Marital status _____ Race _____ Ethnicity _____

Emergency Contact Name & Phone Number _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

Would you like access to the Patient Portal? If yes, provide E-Mail Address_____

PRIMARY INSURANCE INFORMATION *(This information is required)*

Relationship to Patient ( ) Self ( ) Parent ( ) Spouse ( ) Employer ( ) Other _____

Insurance Company _____ Name of Insured _____

Insured's DOB _____/_____/_____ SSN _____-_____-_____ Sex M ( ) F ( )

Insured's ID Number _____ Group Number_____

Insured's Address (if different from patient's) _____ Phone (_____) _____

SECONDARY INSURANCE INFORMATION

Insurance Company _____ Name of Insured _____

Insured's DOB _____/_____/_____ SSN _____-_____-_____ Insured's ID Number _____

Address _____ Effective Date _____/___/_____

ASSIGNMENT OF BENEFITS

I hereby authorize any insurance or other third party benefits to make medical benefits payments, otherwise payable to me for services rendered by John D. Ibrahim, M.D. and his staff payable to and mailed directly to: ***Trinity Doctors Group, P.A., 8133 State Road 54, New Port Richey, FL 34655***. Furthermore, I hereby IRREVOCABLY ASSIGN to Trinity Doctors Group, P.A. the rights and benefits under any polity of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any services and/or changes, provided by Trinity Doctors Group, P.A. Furthermore, the undersigned allows Trinity Doctors Group, P.A. or any of its agents to sign any paper that will be necessary to enhance, expedite and/or allow payment to said provider. This may include insurance forms and other statements.

_____

Patient Name (Patient or Legal Guardian) **Signature** **Date**

_____

Print Witness Name **Signature** **Date**