John Ness, MD, PA.
Dr. Ness Family Practice
616 Universal Drive, Tallahassee, FL 32303
Office 850-385-1839 | *Fax* 850-386-8371

PATIENT INFORMATION

PLEASE COMPLETE BOTH FORMS

DATE: _____

FULL NAME: _____

(FIRST, MI, LAST)

PRIMARY ADDRESS: _____

_____

(INCLUDE CITY, STATE, ZIPCODE)

PHONE: (H) _____ (C) _____

EMAIL ADDRESS: _____

ARE ANY FAMILY MEMBERS AN ACTIVE PATIENT? _____ YES OR NO: _____

NAME(S): _____

GENDER IDENTITY: _____ SEX: _____

SPOUSE: _____

NAME PHONE

EMERGENCY CONTACT: _____

NAME PHONE

PLACE OF EMPLOYMENT: _____

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INSURANCE INFORMATION

PRIMARY INSURANCE: POLICIY #:

INSURED PARTYS NAME:
(FIRST, MI, LAST)

ADDRESS:

(INCLUDE CITY, STATE, ZIPCODE)

☐ CHECK SAME AS PRIMARY ADDRESS

RESPONSIBLE PARTY

I GIVE PERMISSION FOR JOHN NESS, MD, PA TO FILE A CLAIM FOR SERVICES TO MY HEALTH INSURANCE CARRIER. I UNDERSTAND THAT EXPENSES NOT COVERED BY MY INSURANCE ARE MY RESPONSIBILITY, AND THAT I WILL BE RESPONSIBLE FOR ANY CHARGES OF THE ABOVE PATIENT.

1. PRINT NAME OF RESPONSIBLE PARTY

2. SIGNATURE OF RESPONSIBLE PARTY

ADDRESS:

(INCLUDE CITY, STATE, ZIPCODE)

☐ CHECK SAME AS PRIMARY ADDRESS

PHONE: (H) (C)

DATE OF BIRTH: SOCIAL SECURITY NUMBER: