

Patient Name: _____

DOB: _____



Peace Of Mind Internal Medicine, PLLC
318 Tamiami Trail, Suite 226
Punta Gorda, FL 33950
(P) 941-888-0711 (F) 941-505-5069

Patient Information

Personal Information

Full Name: _____
Last First M.I.

Address: _____
Street Address Apartment/Unit #

City State ZIP Code

Home Phone: _____ Cell Phone: _____

Email _____

SSN: _____

Birth Date: _____ Marital Status: _____

Spouse's Name: _____

Employer: _____ Work Phone: _____

Insurance Information

Primary Insurance: _____ Insurance ID: _____

Group #: _____ Copay: \$ _____

Secondary insurance: _____ Insurance ID _____

Group #: _____ Other: _____

Subscriber Relationship to Subscriber: _____ Subscriber DOB: _____

Patient Name: _____

DOB: _____

Consent For Treatment, Assignment Of Benefits And Release Of Information

I have completed this form and certify that I am the patient or duly authorized agent of the patient. I authorize the providers of Peace Of Mind Internal Medicine, PLLC to provide medical care and treatment for me. I hereby authorize payment of benefits to be made directly to Peace Of Mind Internal Medicine, PLLC and/or and providers individually. I understand, as the recipient of services, **REGARDLESS OF INSURANCE COVERAGE**, that **I am ultimately responsible for payment within 30 days of the date of service or statement and billing fees and/or interest may be assessed.**

Patient/Guardian Signature

Date