Reliance Primary & Urgent Care

NEW PATIENT INFORMATION FORM
(PLEASE PRINT)

Last Name:	Home Phone:
First Name: M.I.:	Work Phone:
Address: Apt #	Cell Phone:
City, State, Zip:	Date of Birth:
Sex: Male / Female (Circle One)	Social Security #
Employer/School: Occupation:	E-mail Address:
Veteran: Yes No (Circle One)	Marital Status: M S D W (Circle One)
Ethnicity: (Circle One) White Black Hispanic/Latino Asian Indian Native Hawaiian	

EMERGENCY CONTACT:

Name:	Relationship:
Address:	Phone:

REASON FOR THE VISIT:

INSURANCE INFO: *Primary* *Secondary*

Insurance Name:	Insurance Name:
ID#	ID#
Group#	Group#
Phone:	Phone:
Address:	Address:

PHARMACY INFO:

Name:
Address:
Phone:

8833 Perimeter Park Blvd STE 503 Jacksonville FL 32216 || relianceprimary@gmail.com || **(P)** 904-687-1055 **(F)** 904-687-2141

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MEDICAL HISTORY:

	TOBACCO	YES	NO
	ILLICIT DRUGS	YES	NO
	ALCOHOL	YES	NO

SURGICAL HISTORY:

ALLERGIES:

HOME MEDICATIONS:

Name	Dose (mg)	How many times a day?	Reason

FAMILY MEDICAL HISTORY: (Circle and indicate who)

DIABETES	HIGH BLOOD PRESSURE
HEART DISEASE	BLOOD DISORDER
CANCER	HIGH CHOLESTEROL

REVIEW OF SYSTEMS: (Circle Relevant Symptoms)

Fever / fatigue	Anxiety / depression	Hearing loss / vertigo	Hair loss / heat or cold intolerance
Weight gain / loss	Urinary difficulty	Murmur/chest pain	Palpitations / leg swelling
Skin rash, lesion	Coughing blood	Joint pain / stiffness	Cough/shortness of breath / wheezing
Acid reflux / nausea	Easy bruising	Vomiting / constipation	Hives / eczema / seasonal allergies
Sexual complaints	Sinus trouble / sore throat	Sleep difficulty / mood swings	Double vision / cataract / glasses

VACCINATION HISTORY:

COVID	Date:-	FLU	Date:-
TETANUS	Date:-	PNEUMONIA	Date:-
SHINGLES	Date:-	HEPATITIS B	Date:-

SCREENING FOR CANCER:

COLONSCOPY	DATE	PLACE
PAP SMEAR	DATE	PLACE
MAMMOGRAM	DATE	PLACE
PROSTATE EXAM	DATE	PLACE

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MISSED APPOINTMENT POLICY

IT IS THE POLICY OF RELIANCE MEDICAL ASSOCIATES OF JAX, LLC TO CHARGE **$25.00** (TWENTY-FIVE DOLLARS) FOR MISSED APPOINTMENTS AND APPOINTMENTS THAT HAVE NOT BEEN CANCELLED WITHIN 24 HOURS. THESE CHARGES WILL BE YOUR RESPONSIBILITY AND BILLED DIRECTLY TO YOU. PLEASE HELP US TO SERVE YOU BETTER BY KEEPING YOUR REGULARLY SCHEDULED APPOINMENT,

DATE:_____ SIGNATURE:_____
(RESPONSIBLE PARTY IF MINOR)

PAYMENT AT TIME OF SERVICE

IT IS OUR OFFICE POLICY THAT PAYMENTS ARE DUE AT THE TIME OF SERVICE. IF WE HAVE A CONTRACT WITH YOUR INSURANCE COMPANY, WE WILL FILE YOUR INSURANCE. HOWEVER, **YOU** ARE RESPONSIBLE FOR ALL COPAYS, DEDUCTIBLES, AND NON-COVERED SERVICES AT THE TIME OF SERVICE.

I UNDERSTAND AND AGREE THAT, REGARDLESS OF MY INSURANCE STATUS, I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE OF MY ACCOUNT. I CERTIFY THAT THE INFORMATION PROVIDED ON THE REVERSE SIDE OF THIS FORM IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY YOU OF ANY CHANGES IN THIS INFORMATION. A PHOTOSTATIC COPY OR OTHER REPRODUCTION OF THIS WILL BE AS VALID AS THE ORIGINAL.

DATE:_____ SIGNATURE:_____
(RESPONSIBLE PARTY IF MINOR)

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ASSIGNMENT OF INSURANCE BENEFITS, DIRECTION TO PAY AND AUTHORIZATION FOR INSURANCE INFORMATION

I,_____ HEARBY INSTRUCT AND DIRECT ANY INSURANCE CARRIER THAT IS PROVIDING INSURANCE BENEFITS ON MY BEHALF UNDER ANY POLICY OF INSURANCE TO MAKE OUT A CHECK TO, AND TO DIRECTLY PAY RELIANCE MEDICAL ASSOCIATES OF JAX,LLC FOR ANY AND ALL PROFESSIONAL, MEDICAL, SURGICAL AND /OR REHABILITATIVE SERVICES RENDERED TO ME. THIS INCLUDES A DIRECT ASSIGNMENT OF MY RIGHT AND BENEFITS UNDER ANY POLICY OF INSURANCE AND MAY ONLY BE REVOKED WITH THE EXPRESS WRITTEN CONSENT OF RELIANCE MEDICAL ASSOCIATES OF JAX, LLC. THIS ASSIGNMENT OF INSURANCE BENEFITS PERTAINS TO ANY AND ALL PROFESSIONAL SERVICES, INCLUDING PAST SERVICES PROVIDED BY RELIANCE MEDICAL ASSOCIATES OF JAX, LLC IN RELATION TO ANY HEALTH INSURANCE, MOTOR VEHICLE INSURANCE, AND/OR ANY OTHER INSURANCE THAT MAY PROVIDE ME WITH COVERAGE FOR SERVICES PERFORMED BY RELIANCE MEDICAL ASSOCIATES OF JAX, LLC.

THIS ASSIGNMENT OF INSURANCE BENEFITS IS PROVIDED TO THAT RELIANCE MEDICAL ASSOCIATES OF JAX, LLC MAY ATTEMPT TO COLLECT ANY UNPAID OR OVERDUE INSURANCE BENEFITS FROM ALL INSURANCE CARRIERS. THIS INCLUDES THE ASSIGNMENT OF ANY CAUSE OF ACTION THAT MIGHT ACCURE AGAINST ANY INSURANCE CARRIER FOR ITS FAILURE TO TIMELY PAY FOR SERVICES RENDEREDTO ME BY RELIANCE MEDICAL ASSOCIATES OF JAX, LLC. SUCH ASSIGNMENT IS GIVEN IN CONSIDERATION OF RELIANCE MEDICAL ASSOCIATES OF JAX, LLC ACCEPTING ME AS A PATIENT AND RENDERING PROFESSIONAL, MEDICAL, SURGICAL AND/OR REHABILITATIVE SERVICES.

I AUTHORIZE ANY HOLDER OF INSURANCE INFORMATION ABOUT ME TO RELEASE SUCH INFORMATION TO RELIANCE MEDICAL ASSOCIATION OF JAX, LLC AS REQUESTED TO DETERMINE THE INSURANCE BENEFITS OR TO ASSIST IN THE COLLACTION OF PAYMENT FOR SERVICES. I AUTHORIZE RELIANCE MEDICAL ASSOCIATION OF JAX, LLC TO CONTACT THE INSURANCE COMPANY FOR AN EXACT DOLLAR ABOUT OF INSURANCE BENEFITS THAT ARE AVAILABLE UNDER MY POLICY OF INSURANCE THAT AFFORDS COVERAGE, AND TO OBTAIN ANY PAYOUT OR CHECK LEDGER REFLECTING INSURANCE BENEFITS THAT HAVE BEEN PAID OUT ON MY BEHALF.

I UNDERSTAND THAT HEAR MAY BE SERVICES PROVIDED TO ME BY RELIANCE MEDICAL ASSOCIATES OF JAX, LLC THAT MAY NOT BE PAID IN FULL UNDER THE BENEFITS OF MY INSURANCE POLICIESAND/OR THAT MY INSURANCE POLICIES MAY DENY OR REFUSE TO PAY. I EXPRESSLY UNDERSTAND THAT I AM RESPONSIBLE TO PAY FOR THESE SERVICES IN ADDITION TO ANY AMOUNTS OUTSTANDING FOR CO-PAYMENTS, DEDUCTIBLES, OR NON-COVERED SERVICES.A COPY OF THIS AGREEMENT WILL BE AS VALID AS THE ORIGINAL.

I HAVE READ AND I DO UNDERSTAN THIS ASSIGNMENT OF BENEFITS THOROUGHLY.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE DATE

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AUTHORIZATION TO RELEASE INFORMATION:

I HEREBY AUTHORIZE RELIANCE MEDICAL ASSOCIATES OF JAX, LLCTO FURNISH MY INSURANCE COMPANIES, HOSPITALS, REFERRING OR CONSULTING PHYSICIANS AND BILLING AGENTS ALL INFORMATION WITH REGARD TO MY MEDICAL CARE.

DATE:_____ SIGNATURE:_____
(RESPONSIBLE PARTY IF MINOR)

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