PLEASE PRINT

Name:_____ Referred By:_____
LAST FIRST MIDDLE

Local Address: _____ City: _____ State: _____

Zip Code: _____ Telephone: _____ Cell: _____Date of Birth: _____

Social Security #: _____Race: ☐ African American ☐ Caucasian ☐ Other ☐ Decline

Ethnicity: _____ ☐ Decline Email: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Employer: _____Telephone:_____

Primary Care Physician (PCP):_____ PCP Telephone: _____

Cardiologist: _____ Telephone:_____

Name of Primary Insurance: _____ Name of Insured: _____

Subscriber or Contract Number: _____ Group Number: _____

Name of Second Insurance: _____ Name of Insured: _____

Subscriber or Contract Number: _____ Group Number: _____

Pharmacy: _____ Location: _____ Telephone: _____

In case of emergency, who should be notified? _____ Telephone: _____

Permission to release health information to: _____

CONSENT FOR E-PRESCRIBING & MEDICATION HISTORY

I understand that as a part of my electronic health record, Anesthesiology of Jupiter d/b/a Jupiter Pain Management will transmit my prescriptions electronically as permitted, to the pharmacy that I designate as my primary pharmacy provider. Additionally, APM will obtain the history of all of my past prescriptions dating back two years from pharmacy benefit managers and I understand that those prescriptions will become a part of my electronic health record. By signing below I hereby give consent to the above actions.

Signature of Patient or Legal Representative**:** _____Date: _____

RECORD RELEASE & ASSIGNMENT OF INSURANCE

I hereby authorize Anesthesiology of Jupiter d/b/a Jupiter Pain Management., to re-release any and all medical information that has been previously requested from any physician, hospital, or clinic where I have been treated. I also understand that **this authorization to re-release medical information shall only be valid for the purposes of second opinions or referral from Anesthesiology of Jupiter d/b/a Jupiter Pain Management for additional specialist evaluation.** I acknowledge that I have received a copy of the "Notice of Privacy Practices" which sets forth Anesthesiology of Jupiter d/b/a Jupiter Pain Management privacy practices and my rights regarding privacy of my PHI. I acknowledge full responsibility for the payment of services rendered to me and agree to pay for them in full, at the time of service, **unless other arrangements are made in advance**. I hereby authorize the payment of benefits of my insurance policy, if any, to be paid directly to Anesthesiology of Jupiter d/b/a Jupiter Pain Management for services rendered. I further authorize the release of any medical information required by my insurance carrier. I understand that I am financially responsible for any charges incurred in the collection of this account, should I default on payment. Such charges include, but are not limited to legal fees, collections fees, interest charges or late charges.

Signature of Patient or Legal Representative**:** _____Date: _____