S. TRACY RHODES, M.D., P.A.
5558 Lake Howell Road
Winter Park, FL 32792

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Phone: 407-679-3400
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PATIENT INFORMATION

Patient Name: _____ **Date of Birth:** ____/____/_____
LAST FIRST MIDDLE INITIAL

Home Address: _____ _____ _____ _____
STREET CITY STATE ZIP CODE

Home #: _____-_____-_____ **Cell #:** _____-_____-_____ **Email** _____

SSN: _____-_____-_____ **Gender: F M Other** **Preferred Contact: Email / Home # / Cell # / Mail**

Occupation: _____ **Marital Status: Married / Single / Domestic Partner / Divorced / Widowed**

Ethnicity: Latino / Hispanic / Other / Prefer Not to Say

Race: Caucasian / African American / Asian / Pacific Islander / American Indian / Other: _____

EMERGENCY CONTACT INFORMATION

Contact Name: _____ **Relationship to Patient:** _____

Contact Phone #: _____-_____-_____

PHARMACY INFORMATION

Local Pharm. Name: _____ **Local Pharm. #** _____-_____-_____

Local Pharm. Location: _____
FULL ADDRESS OR STREET CORNERS

Prescription Insurance Information: **RXBIN:** _____ **RXPPCN:** _____ **RXGRP:** _____
(LOCATED ON PRESCRIPTION INSURANCE CARD)

Mail Order Pharm. Name: _____ **Mail Order Pharm. #:** _____-_____-_____
(IF APPLICABLE)

Please read and initial the statements below and then sign and date the bottom. If any questions, feel free to ask front desk for clarification.

_____ **Yes, I give consent to share clinical documentation with other doctors, if necessary.**

_____ **I understand that as of January 1, 2020 I am responsible for submitting office visit claims to my insurance.**

_____ **I understand that I am responsible for paying the annual practice fee before January 1st of the following year.**

_____ **I understand that I am responsible for keeping this office updated with my insurance information.**

_____ **It is my understanding that this office is relying on this information I have provided. I affirm that all information above is true and correct.**

_____ _____
PATIENT / LEGAL GUARDIAN SIGNATURE TODAY'S DATE