6 Office Park Drive
Palm Coast FL 32137
Phone (386) 447-6615
Fax (386) 447-1266

MEDIQuick
www.mediquickfl.com

140 Pinnacles Drive
Palm Coast FL 32164
Phone (386) 597-2829
Fax (386) 313-1923

Patient Registration Information Today's Date: ________ /________ /_______

Social Security Number: __________-_________-__________

Name: First ______________________________ Middle _________ Last___________________________________

Sex: □Male □Female Date of Birth: _______ /_______ /________

Marital Status: □Married □Single □Divorced □Widowed Email address: ____________________________

Mailing Address: ____

City: ________________________________ State: _____________________ Zip Code: ________________________

Phone: Home ( ) ____________________Cell ( ) ___________________ Work ( ) ______________________

Check one: Employed □ Employer _________________________ □Retired □Student □Other ___________________

Primary Insurance Information

Insurance Company: _____________________________ Name of Policy Holder ______________________________

Date of Birth of Policy Holder: _______ /_______/ _______ Policy Holders SSN: _________-_________-_________

Relationship to Policy Holder: □Child □Wife □Husband □Other____________________________________

Insurance Number: __________________________________ Group: ______________________________________

Emergency Contact Information (Required)

Relationship to Patient: _____________________________ Phone Number: ___________________________

Name: First ______________________________ Middle _________ Last___________________________________

Mailing Address: ____

City: _______________________________ State: _____________________ Zip Code: ________________________

Please Read and Sign

- I certify that the above information is true and correct to the best of my knowledge.
- I authorize the release of any medical information necessary to process this claim and also request payment of insurance benefits either to myself or to the party who accepts assignments.
- I authorize release of medical payment to MEDIQUICK
- I understand that should my account fall into arrears and be sent off to a collection agency or credit bureau, I will be responsible for any fees incurred.
- I understand that if my insurance company does not cover all of the professional service charges incurred, that I am responsible for any balance above insurance payment.
- Consent for treatment: I hereby consent the Provider to render medical evaluation treatment and the performance of diagnostic testing and procedures according to the Provider's discretion. **No guarantees will be made as to the results of examinations and or treatments.**
- I understand MediQuick may occasionally send a text and or email for review of services.

Signature: ____ **Date**: _________________________