Dennis D. Dewey, M.D., P.A.
1895 Kingsley Ave., Suite 805
Orange Park, FL 32073

Referring Physician _____ Today's Date _____

Patient Last Name _____ First Name _____ MI ____

Patient Address _____ City _____ State _____ Zip ____

Phone# Home _____ Cell _____ Work _____

Social Security # _____ Date of Birth _____ M____ F____ Marital Status ____

Emergency Contact _____ Relationship _____ Phone# _____

Ethnicity _____ Preferred Language _____ Race _____ **EMAIL** _____

Primary Insurance Information

Insurance Name _____ ID# _____ Group# _____

Policyholder Name _____ Policyholder Date of Birth _____

Insurance Address _____ Phone# _____

Employer Name _____

Secondary Insurance Information

Insurance Name _____ ID# _____ Group# _____

Policyholder Name _____ Policyholder Date of Birth _____

Insurance Address _____ Phone # _____

Employer Name _____

Do we have permission to:
Leave a message on your answering machine at home? Yes No On your cell phone? Yes No
Leave a message at your place of employment? Yes No
Discuss your medical condition or billing with family members? Yes No

Payments are due at the time services are rendered. We will file your insurance for you however any balance is t patient's responsibility. I hereby authorize direct payment of medical benefits to Dennis Dewey, M.D. for service rendered by any of the listed persons or under the listed person supervision. I also authorize the release of any medical incidental information that may be necessary for either medical care or processing applications for financ benefits. I authorize release of all records upon request. I request that payment of authorized benefits be made my behalf to Dennis D. Dewey, M.D.

Patient Signature _____ Date _____

Responsible Party/Guardian _____ Relationship _____