UF Family Practice

[ ] West Oaks Family Health
[ ] Family Practice at Medical Plaza
[ ] Haile Plantation
[ ] Fanning Springs
[ ] Eastside Community Practice
[ ] Family Practice Medical Group
[ ] Other ____________________

Patient Information

Name ______________________________ SSN ______________________________
Address ______________________________ DOB ______________________________
City/State/Zip ______________________________
Home Phone # ____________________ Work Phone # ______________________________

In case of emergency, notify ______________________________
name and relationship

Emergency Phone Numbers
Home Phone # ____________________ Work Phone # ______________________________

Insured's Information (*complete the next two lines if different than the patient's information)*

Insured's Name ______________________________ Relationship ____________________
Insured's DOB ____________________ Insured's SSN ______________________________

Insurance Company ______________________________ Phone # ____________________
Insurance Address ______________________________
ID # ______________________________ Group # ______________________________

**If you are being seen under Worker's Compensation, check here [ ] and please list name of company in the above insurance information.

[ ] **See copy of insurance card**

Insured's Employer ______________________________
Address ______________________________
City/State/Zip ______________________________
Work Phone # ______________________________

Name of previous physician or provider ______________________________
Address ______________________________
City/State/Zip ______________________________
Phone # ______________________________

For Office Use Only: (*form should be updated at least yearly)*

Patient Information updated and revised on ____________________