KENNETH B. HAWTHORNE, JR., M.D., P.A.
106 N. Old Kings Road, Suite E
Ormond Beach, FL 32174
Phone 386-671-0115
Fax 386-671-0844

Date _____

First Name _____ Last _____ Middle Initial _____

Mailing Address _____ Apt.# _____

City _____ State _____ Zip _____

Phone _____ Date of Birth _____ S.S. #: _____

Cell No. _____ E-Mail _____

Sex : ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Age _____

Work Phone No. _____ Employer _____ Occupation _____

Emergency contact Name _____ Relationship _____

Emergency No. _____ Date of onset of symptoms or accident _____

Car accident _____ Work Accident _____ Accident _____ Illness _____

Reason for Visit _____

Name of Attorney _____

PRIMARY INSURANCE CARRIER

Name of InsuranceCompany _____

Name of Policy Holder _____ Date of Birth _____

Policy No. _____ Group # _____ Co-Pay $ _____

SSN# of Policy Holder _____ Relationship to Patient _____

Employer _____ Employer Phone # _____ Deductible $ _____

SECONDARY INSURANCE CARRIER

Name of Insurance Company _____

Name of Policy Holder _____ Date of Birth _____

Policy No. _____ Group# _____ Co-Pay $ _____

SSN # of Policy Holder _____ Relationship to Patient _____

Employer _____ Employer Phone No. _____ Deductible $ _____

RELEASE OF ASSIGNMENT

TO MY INSURANCE CARRIER(S)

1. I authorize the release of any medical information necessary to process my insurance claim.
2. I authorize and request payment of medical benefits directly to my physicians.
3. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me.
4. I agree that a photocopy of this form be used in lieu of the original.

_____ _____

Signed (patient or representative) Date