Addiction Care of Excellence

An Outpatient Medical Recovery Program

New Patient Registration

Please print and complete all entries

Patient Information

Patient name – Last, First, Middle				
SSN:	Date of Birth	Marital Status: Single, Married, Divorced, Widowed	Age	Gender: Male Female
Local address				Zip Code
Home phone	Work phone, ext.	Email address:		
Permanent address, if not Florida resident				Phone at this address
Patient employer:				
Spouse name:	Spouse SSN:	Spouse employer:		
Emergency contact:		Relationship:	Phone:	
Referring physician (name, specialty):				

Primary Insurance – please show insurance card

Company name	Identification #	Group#
Claims Address		Claims phone
Policy holder Name if different from patient:		Policy holder SSN:

Secondary Insurance – please show insurance card

Company name	Identification #	Group#
Claims Address		Claims phone
Policy holder Name if different from patient:		Policy holder SSN:

Guarantor – if different from patient and policy holder

Name	Relation to patient	Date of Birth	Home phone
Mailing address			

Automobile or Workers Compensation Insurance

Is this visit due to an accident? Yes No	Related to Work? Yes No	Automobile? Yes No	Both? Yes No
State where accident occurred	Date of accident:	Auto claim #	
Workers Compensation #	Auto or Workers compensation insurance carrier		
Claim Address		Claim phone	