

Arthritis and Sports Care Center, Inc.
Hulon E. Crayton, M.D.
2917 Highway 77, Panama City, Florida 32405
(850) 873-6748 Fax (850) 913-1820

REASON FOR TODAY'S VISIT:

HOW DID YOU HEAR OF DR. CRAYTON?

ALLERGIES TO MEDICATIONS:

LIST ALL MEDICATION CURRENTLY TAKING:

REFERRING PHYSICIAN'S NAME: (WRITE ON LINE BELOW) **PRIMARY CARE PHYSICIAN'S NAME:**

PATIENT NAME: LAST: FIRST: MIDDLE:

ADDRESS: CITY: STATE: ZIP:

HOME PHONE: MARITAL STATUS: STUDENT STATUS:

SOCIAL SECURITY NO. SEX: DATE OF BIRTH:

EMPLOYER: OCCUPATION: WORK PHONE:

SPOUSE/PARENT INFORMATION:

NAME: LAST: FIRST: MIDDLE:

ADDRESS: CITY: STATE: ZIP:

HOME PHONE: WORK PHONE: DATE OF BIRTH: SSN #

IN CASE OF EMERGENCY, WHO SHOULD WE CONTACT?

NAME: LAST: FIRST: MIDDLE:

ADDRESS: CITY: STATE: ZIP:

HOME PHONE: WORK PHONE: HOW RELATED?

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE AND/OR MEDICAL INSURANCE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF FOR ANY SERVICES FURNISHED ME BY ARTHRITIS AND SPORTS CARE CENTER, INC. I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS FOR RELATED SERVICES. I REQUEST THAT PAYMENT OF AUTHORIZED SECONDARY BENEFITS BE MADE ON MY BEHALF TO ARTHRITIS AND SPORTS CARE CENTER INC. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO ANY OF MY INSURANCE COMPANIES ANY INFORMATION NEEDED TO DETERMINE THERE BENEFITS PAYABLE OF RELATED SERVICES. I HEREBY AUTHORIZE PAYMENT DIRECTLY TO ARTHRITIS AND SPORTS CARE CENTER INC. OTHERWISE PAYABLE TO ME. I UNDERSTAND AND AGREE THAT ANY UNPAID BALANCE NOT COVERED BY THIS POLICY WILL BE PAYABLE BY ME.

SIGNED:

DATE:

I ALSO UNDERSTAND AND AGREE THAT IF I DO NOT GIVE THE REQUIRED 24 HOUR ADVANCED NOTICED FOR CANCELED APPOINTMENTS, I WILL BE CHARGED A \$25.00 NO SHOW CHARGE. **SIGNED:** **DATE:**