KAHLIL A. SHILLINGFORD, M.D., P.A.
9960 CENTRAL PARK BLVD., N.
Suite 235
BOCA RATON, FL 33428
PHONE: (561) 483-8840
FAX: (561) 483-3342

PATIENT INFORMATION

NAME: ______________________________ DATE: ______________

ADDRESS: ____

CITY: _________________ STATE: _________ ZIP: ______________

PHONE #: _____________________ CELL #: ___________________

SS#: ___________________ DOB: _____________ AGE: __________

RACE: Asian / Caucasian / Black or African American / Hispanic / Unknown

ETHNICITY: (Hispanic or Latino): Yes / No

LANGUAGE: ____

E-MAIL ADDRESS: ____

S M D PARTNER/SPOUSE NAME: ____________________________

EMPLOYER INFORMATION:

EMPLOYER: _____________________ ADDRESS: ________________

WORK PHONE: __________________ POSITION: _________________

PRIMARY INSURANCE INFORMATION:

INSURANCE NAME: ____________________ ADDRESS: __________________

ID#: __________________________________ GROUP: ____________________

PHONE #: _________________ SUBSCRIBER'S NAME: ____________________

SUBSCRIBER'S SS#: _________________________ DOB: _________________

SECONDARY INSURANCE:

INSURANCE NAME: __________________ ADDRESS: ____________________

ID#: _________________________ GROUP: ______________________________

PHONE #: ______________ SUBSCRIBER'S NAME: ________________________

SUBSCRIBER'S SS#: _________________ SUBSCRIBER'S DOB: ___________

REFERRED BY:

DOCTOR: ________________________________ PHONE #: ________________

ADDRESS: ______________________________ FAX #: ___________________

OTHER RESOURSE: ____

Assignment of Benefits/Medical Information Release: I request that payment of authorized Medicare/Insurance benefits be made on my behalf to Kahlil A. Shillingford, M.D. for any services furnished to me. I authorize any holder of medical information about me to release any information needed to determine the benefits payable for related services.

I hereby authorize Medicare to furnish to the above named doctor any information regarding my Medicare claims under Title XVIII of the Social Security Act. I hereby assign benefits to Kahlil A. Shillingford, M.D./group indicated on this claim. Having insurance is not a substitute for payment. I understand I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature is as valid as the original.

SIGNATURE: ______________________________ DATE: __________________

EMERGENCY CONTACT:

NAME: _____________________________ PHONE #: __________________

PATIENT MEDICAL INFORMATION:

REASON FOR CURRENT VISIT: ______________________________________

ALLERGIES: LIST ALL ALLERGIES AND REACTION: ___________________

____

ALLERGIC TO LATEX? YES: ___ NO: ____ REACTION: ______________

SMOKER? YES: _____ NO: _____ HOW MUCH? ____________________

ALCOHOL? YES: _____ NO: _____ HOW MUCH? ___________________

ILLICIT DURGS? YES: _____ NO: ______ WHAT? __________________

CURRENT MEDICATIONS: LIST ALL AND DOSE AND HOW TAKEN:

____

____

CURRENT MEDICAL CONDITION: ___________________________________

PAST HOSPITALIZATIONS: ____

PAST SURGERIES: ____

FAMILY MEDICAL HISTORY: _______________________________________

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I am choosing to enter into medical services with Kahlil A. Shillingford, M.D., P.A.

As my appointment time has been set aside exclusively for me, I understand that I am responsible for the appointment fee, or a $25 cancellation fee, if I fail to cancel a scheduled appointment at least 24 hours in advance. I understand that my insurance company will not pay for missed visits.

I understand that payment or co-payment is due at the time services are rendered unless special arrangements have been made. I understand the billing department will be glad to file my insurance claims for me; however, payment cannot be guaranteed. I will be responsible for any unpaid balances not covered by my insurance company.

Any balance overdue more than thirty days will be subject to a $25 late fee per month. I agree to pay the cost of any delinquent bill, including a reasonable attorney's fee and/or collection agency fee and interest fee. I understand my account may be sent to a collection agency or court if fees are not paid in a timely manner.

I fully understand and agree to the above policies and conditions. A copy of this signature is as valid as the original.

____

Patient/Guardian

Kahlil A. Shillingford, M.D., P.A.
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As of June 1, 2011, Dr. Kahlil Shillingford will only prescribe medications 30 days post operatively, based on clinical need.

Dr. Shillingford reserves the right to discontinue prescription coverage at his discretion; if you believe you are in need of further medications on a long term basis, you must contact your PCP or Pain Management Physician.

_______________________________________ ________________

Patient/Guardian Date

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ATTENTION:

"Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. However, certain physicians who meet state requirements are exempt from the financial responsibility law. **YOUR DOCTOR MEETS THESE REQUIREMENTS AND HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE.** This notice is provided pursuant to Florida law."

____

Patient/Guardian

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Medical Records Release Form

Date: ____/____/____

To Whom It May Concern:

I hereby authorize any physician, hospital or medical facility the release of any information acquired in the course of my treatment or examination to Kahlil A. Shillingford, M.D.

Please fax all recent labs, test results and H&P including diet and exercise history to (561) 483-3342.

____________________ ____________________

Patient's Name Patient/Guardian Signature

Patient's DOB: ____/____/____