1380 NE Miami Gardens Dr., Suite 210, North Miami Beach, Fl 33179
Office: 305 692 9009 www.worldmedicalcare.com
Fax: 305 501 4220 info@worldmedicalcare.com

PLEASE REPLY TO ALL QUESTIONS/ PLEASE PRINT CLEARLY

Last Name:

First Name:

Primary Language:

Date of Birth: / / **Age:** **Sex:** M / F
month day year **Marital Status:** S M D W

Email:

Permanent Address:

City: **Postal Code:**

Home Phone:

Cell Phone/ Alternative Phone:

Florida Adress:

City: **State: FL** **Zip Code:**

Emergency Contact

Name: **Telephone:**

Travel Dates: -
mth / day/ year mth / day/ year

Medical reason for visit:

Insurance Iinformation

Insurance name:

Policy No.: **Group No.:**

Authorization/Claim No.: **File No.:**

Release of Information Authorization

I hereby authorize the release of any medical or other information necessary to process insurance claim(s) arising from my treatment(s) received at World Medical Care.

Signature of patient or authorized person. **Date:**

Assignment of Benefits

I hereby authorize payment of medical benefits directly to the physician/ World Medical Care for medical services rendered.

Signature of patient or authorized person. **Date:**

HOW DID YOU HEAR ABOUT US? ……..