Medical Associates OF CENTRAL FLORIDA


Amy Davis, MSN ARNP
Primary Care


Mahesh G Allam, MD
Internal & Pulmonary Medicine
Sleep Disorders


Nakisha Watson, ARNP
Primary Care

Your Health Care Partner in Primary Care

Welcome to Medical Associates of Central Florida. Please complete this form.

Email Address: _____

Patient's Name:_____ Age:_____ Date of Birth:_____

Patient's Social Security Number:_____ Cell Phone: _____

Address:_____ City:_____ State:___ Zip:_____

Out of State Address:_____ City:_____ State:___ Zip:_____

Home Phone:_____ Sex:_____ Height:_____ Weight:_____ Race:_____ Married:___ Single:___

Employer:_____ Phone:_____

Responsible Party (If Minor) Father:_____ Mother:_____

Resp Party Address:_____ City:_____ State:___ Zip:_____

Patient Referred By:_____ Family Physician:_____

Spouse's Email Address:_____

Spouse's Name:_____ Spouse's Date of Birth: _____

Spouse's: Social Security Number:_____ Spouses Cell Phone: _____

Spouses' Employer:_____ Employe Phone:_____

Employer Address:_____ City:_____ State:___ Zip:_____

Name of Nearest Relative:_____ Relationship:_____ Phone:_____

Address:_____ City:_____ State:___ Zip:_____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical / medical benefits to Dr. Allam/Dr Nelson/Nakisha Watson and Medical Associates of Central Florida for services rendered by him in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Dr. Allam/Amy Davis, ARNP/Nakisha Watson, ARNP and Medical Associates of Central Florida, to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

MEDICARE - MEDICAID - MEDIGAP

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

PATIENT SIGNATURE:_____ DATE:_____

rev 12/17/20

A photocopy of these assignments shall be valid as the original.

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