Affiliated Physician
MDVIP

Lara Hitchcock, MD, FAAFP
Family Medicine

Hitchcock Health Institute

Patient Information Sheet

Today's Date: ______/_____/_____

Name: _____ DOB: _____ Marital Status: _____

Last 4 of SSN: _____ Primary Phone #: (_____)_____-_____ Secondary #:(_____)_____ -_____

Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

Employer: _____ Work #: (_____) _____ - _____

*** I understand this office may utilize automated reminder messages and I authorize to be contacted in such a manner***

_____ **(Signature Required)**

Insurance Information

Insurance Company Name: _____ Policy / ID #:_____

Insurance Address: _____Phone #: _____

Policy Holder: _____ Policy Holder DOB: _____ Relationship: _____

Have you verified that Dr. Hitchcock is in your network? (Please check one)

_____ Yes

_____ No ***(Please call your insurance company to verify that you have coverage benefits, or you may be responsible for the entire cost of this and any future visits)***

Emergency Contact

Name: _____ Phone #: _____ Relationship: _____

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Suite 201
Orlando, FL 32819

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F 407.447.9598

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