Welcome to DOCs family. Please fill out the following information prior to your appointment.

Exam location

Which location is your exam scheduled?

St. Petersburg ☐ Leesburg ☐ Eustis ☐ Ocala ☐

First Name_____

Middle Initial_____

Last Name_____

Date of Birth Month_____Day_____Year_____

Gender Male_____ Female_____

Social Security # _____-_____-_____

Home Address_____

City _____

State _____

Zip _____

Home Phone Number _____

Cell Phone Number _____

Work Phone Number _____

Email Address _____

Emergency Contact Person _____
Relationship_____

Emergency Contact Number wk: _____

Emergency Contact Number home/ cell _____

Are you employed? _____

Employer _____

Employer Phone Number _____

Insurance Information

Primary Insurance Carrier _____

Policy # _____

Group # _____

Group Name _____

Secondary Insurance Carrier _____

Policy # _____

Group # _____

Group Name _____

Policy Holder Information

Please fill out this information ONLY if the policy holder is different from the patient.

How is the patient related to the policy holder? _____

Policy Holder's First Name _____

Middle Initial _____

Last Name _____

Date of Birth Month _____ Day _____ Year_____

Policy Holder's Address _____

City _____

State _____

Zip _____

Home Phone _____

Cell Phone _____

Note: Most of our exams will require additional exam history information. These exam forms are not currently available online but will be given to you at our office to complete.

Thank you!

eMail **Print**