

**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: \_\_\_\_\_

S M D PARTNER/SPOUSE NAME: \_\_\_\_\_

**EMPLOYER INFORMATION:**

EMPLOYER: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

WORK PHONE: \_\_\_\_\_ POSITION: \_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_

**INSURANCE INFORMATION:**

INSURANCE NAME: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

ID#: \_\_\_\_\_ GROUP: \_\_\_\_\_

PHONE #: \_\_\_\_\_ GUARANTOR'S NAME: \_\_\_\_\_

GUARANTOR'S SS#: \_\_\_\_\_ DOB: \_\_\_\_\_

ON THE JOB INJURY: Y/N AUTO ACCIDENT: Y/N

DATE OF ACCIDENT/INJURY: \_\_\_\_\_ STATE ACCIDENT  
OCCURRED: \_\_\_\_\_

WORKER'S COMP CLAIM #: \_\_\_\_\_

ADJUSTER NAME AND PHONE #: \_\_\_\_\_

SECONDARY INSURANCE:

INSURANCE NAME: \_\_\_\_\_ ID #: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

REFERRED BY:

DOCTOR: \_\_\_\_\_ PHONE #: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ FAX #: \_\_\_\_\_

**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 surgical 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.**

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**Patient/Guardian**

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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.**

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**Patient/Guardian**

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**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."**

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**Patient/Guardian**

