

**Hyperbaric Services of the Palm Beaches, LLC**  
**5130 Linton Blvd., Suite H3 & 4**  
**Delray Beach, FL 33484**  
**561-819-6125 Fax 561-819-6127 800-983-8582**

**Patient Information**  
(Please Print)

Date: \_\_\_\_\_

Name: \_\_\_\_\_ S.S. #: \_\_\_\_\_

Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Are you from out of town? Yes or No If yes, your local address and phone number:

\_\_\_\_\_

Circle Status: Minor Single Married Divorced Widowed Separated

If Minor, Parent or Legal Guardian: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work/Cell Phone: \_\_\_\_\_

Person Responsible for the Bill: \_\_\_\_\_

Address & Phone Number: \_\_\_\_\_

Employer, Address & Phone Number: \_\_\_\_\_

\_\_\_\_\_

Is this patient covered by insurance? Yes or No Please indicate primary insurance:

MEDICARE HUMANA AVMED AETNA BC/BS NHP CIGNA WORKCOMP

OTHER: \_\_\_\_\_

Subscribers Name: \_\_\_\_\_ S.S. #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Group #: \_\_\_\_\_ Policy#: \_\_\_\_\_

Patient's Relationship to Subscriber: SELF SPOUSE CHILD OTHER \_\_\_\_\_

Secondary Insurance (If Applicable) \_\_\_\_\_

Subscribers Name: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_

Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_

Patients Relationship to Subscriber: SELF SPOUSE CHILD OTHER \_\_\_\_\_

**IN CASE OF EMERGENCY:** Name of Local Friend or Relative (not living at the same address): \_\_\_\_\_ Relationship: \_\_\_\_\_

Home/Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**(PLEASE GIVE YOUR INSURANCE CARD(S) TO THE RECEPTIONIST)**

**Physician Information**

Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Hyperbaric Services of the Palm Beaches, LLC or insurance company to release any information required to process my claims.

\_\_\_\_\_  
PATIENT/GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE

EMAIL US AT: [www.oxygen4u@bellsouth.net](mailto:www.oxygen4u@bellsouth.net)