PATIENT'S NAME AND ADDRESS	DATE OF BIRTH
INSURED'S NAME IF PATIENT IS A DEPENDENT	POLICY NUMBER

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the undersigned Physician to release any information acquired in the course of my examination or treatment.

SIGNED (PATIENT, OR PARENT IF MINOR) DATE

Mulit — Lines
P.O. Box 12082
Tallahassee, FL. 32317

ATTENDING PHYSICIAN'S STATEMENT

PART B

1. DIAGNOSIS AND CONCURRENT CONDITIONS (IF DIAGNOSIS CODE OTHER THAN ICDA* USED, GIVE NAME)

2. IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT? YES ☐ NO ☐ PREGNANCY? YES ☐ NO ☐ IF YES, APPROXIMATE DATE PREGNANCY COMMENCED:

3. REPORT OF SERVICES (OR ATTACH AN ITEMIZED BILL) (If previous form submitted to this carrier, you need show only dates and services since last report.)

DATE OF SERVICES	PLACE OF SERVICES	DESCRIPTION OF SURGICAL OR MEDICAL SERVICES RENDERED	PROCEDURE CODE - IF USED	CHARGES

TOTAL CHARGES $

AMOUNT PAID $

BALANCE DUE $

4. DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED:

5. DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION:

6. PATIENT EVER HAD SAME OR SIMILAR CONDITION? YES ☐ NO ☐ IF YES, DESCRIBE WHEN:

7. PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? YES ☐ NO ☐

8. PATIENT WAS CONTINUOUSLY TOTALLY DISABLED (UNABLE TO WORK) FROM TO

9. PATIENT WAS PARTIALLY DISABLED FROM TO

10. IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK:

11. PATIENT WAS HOUSE CONFINED FROM TO

12. DOES PATIENT HAVE OTHER HEATH COVERAGE? YES ☐ NO ☐ IF YES, PLEASE SPECIFY:

DATE PHYSICIAN'S NAME (PRINT) SIGNATURE DEGREE SSN OR FEDERAL TAX

STREET ADDRESS CITY STATE ZIP PHONE