Triana Prevention Center
3155 Harbor Blvd., Ste. 100
Port Charlotte, FL 33952
941-625-1990 FAX 941-625-1991

Elizabeth A. Triana, M.D.
Family Practice

PATIENT INFORMATION SHEET

Today's Date:_____

Name _____ Sex: ☐ Female ☐ Male

Social Security Number _____ Date of Birth:_____ Age _____

Local Home Address: _____

City:_____ Zip Code: _____

Local Phone Number: _____Cell Phone Number_____

Employer's Name: _____

Employer's Address: _____

City:_____ Zip Code: _____

Phone Number: _____

Marital Status: ❑ Married ❑ Divorced ❑ Single ❑ Widow

Spouse's Name: _____

Name of person to notify in case of emergency: _____

Phone: _____

Insurance (Please provide us with your cards for Photo Copying and Review)

Primary Insurance Company: _____

Supplemental Insurance Company: _____

Consents:

I authorize Dr. Triana's office to bill my insurance carrier or carriers on my behalf and assign payments to Dr. Elizabeth Triana. This is to include commercial insurance carriers and or Medicare Part B and supplemental insurance.
I authorize the release of my Medical records to my insurance carriers if requested in order to pay my claims with Dr. Triana.
I understand that payment of fees incurred are my responsibility and agree to pay the portion allowed, but not covered by my insurance and further understand that a default of payment may result in my account being sent to a collection agency. Any additional costs to collect payment of this debt will be paid by me (the patient/guardian).

Patient's or guardian's signature: _____