Central Florida Rheumatology Consultants, LLC

Lance Feller, MD, FACR
Board Certified in Rheumatology

PATIENT REGISTRATION

PATIENT

Full Name: _____ Age: _____ DOB: _____ Sex: _____

Mailing Address: _____City: _____State:_____ Zip: _____

Physical Address: _____ City: _____State:_____ Zip: _____

(IF P.O. BOX IS LISTED ABOVE)

SOCIAL SECURITIY

Number: _____Home #: _____Cell #:_____

Patient Employer: _____ Phone #:_____

Referring Physician: _____ Phone #: _____

INSURANCE INFORMATION

Primary Insurance: _____ Policy #:_____ Group #:_____

Primary Card
Holders Name: _____DOB: _____Social Security #:_____

Secondary
Insurance: _____ Policy #: _____ Group #: _____

Secondary Card
Holders Name: _____DOB: _____ Social Security #:_____