

TODAY'S DATE

**WHO MAY REGISTER**

Adults 18 or older covered by one of our approved insurance plans.  
Through June 30, 2026 — exclusive enrollment for Vero Beach Pediatrics patient families.  
Once complete, please submit to: [careteam@verobeachadultmedicine.com](mailto:careteam@verobeachadultmedicine.com)

**PATIENT INFORMATION**

*Required fields marked with \**

LAST NAME \*  FIRST NAME \*  M.I.

PREFERRED / FIRST NAME USED  FORMER LAST NAME (IF ANY)

DATE OF BIRTH \*  MARITAL STATUS  PREFERRED LANGUAGE

RACE  ETHNICITY

**LEGAL SEX**  Male  Female  X / Nonbinary  Unknown

**HOMEBOUND PATIENT?**  Yes  No

**CONTACT INFORMATION**

STREET ADDRESS \*  APT / SUITE

CITY \*  STATE \*  ZIP \*

MOBILE PHONE \*  HOME PHONE  WORK PHONE

EMAIL (REQUIRED FOR PORTAL ACCESS) \*  BEST WAY TO REACH YOU  Mobile  Home  Email

OK TO SEND APPOINTMENT REMINDERS BY TEXT?  Yes  No

**PREFERRED PHARMACY, LAB & IMAGING**

*Helps us send prescriptions and orders to the right place*

PREFERRED PHARMACY (NAME & LOCATION)  PREFERRED LAB  PREFERRED IMAGING / RADIOLOGY

**EMERGENCY CONTACT & NEXT OF KIN**

**EMERGENCY CONTACT**

FULL NAME \*   
RELATIONSHIP   
PHONE

**NEXT OF KIN**

FULL NAME   
RELATIONSHIP   
PHONE

**EMPLOYMENT & HOW YOU HEARD ABOUT US**

EMPLOYER NAME  EMPLOYER PHONE  OCCUPATION

**HOW DID YOU HEAR ABOUT US?**

Referring Physician   
  Specialist   
  Word of Mouth   
  Advertising / Online  
 Insurance Co.   
  Current Patient   
  Hospital   
  Other

IF OTHER — REFERRING PROVIDER / SOURCE

**PRIMARY INSURANCE**

*Please present your insurance card at check-in*

INSURANCE PLAN NAME \*  MEMBER / ID NO. \*  GROUP NO.

**POLICY HOLDER**

*Leave blank if patient is the policy holder*

Self   
  Spouse   
  Parent   
  Other

LAST NAME  FIRST NAME  DATE OF BIRTH

EMPLOYER  PHONE

**SECONDARY INSURANCE**

*Only if you have a second plan*

INSURANCE PLAN NAME  MEMBER / ID NO.  GROUP NO.

**POLICY HOLDER**

Self   
  Spouse   
  Parent   
  Other

LAST NAME  FIRST NAME  DATE OF BIRTH

**GUARANTOR / FINANCIAL RESPONSIBILITY**

*Person legally responsible for payment, if not the patient*

FULL NAME  DATE OF BIRTH  PHONE

ADDRESS (CITY, STATE, ZIP)

**ACKNOWLEDGMENT & SIGNATURE**

I certify that the information I have provided is accurate to the best of my knowledge. I authorize Vero Beach Adult Medicine to release medical information necessary to process insurance claims and to coordinate my care. I understand that I am financially responsible for any balance not covered by my insurance.

PATIENT OR GUARDIAN SIGNATURE  DATE

**FOR OFFICE USE ONLY**

ID VERIFIED    
 INSURANCE VERIFIED    
 DATE ENTERED