

4 Middle Road, George Town Grand Cayman

**Patient ID** (Office use only)

**Please select the doctor you wish to see:**

Dr. Komal Lawrence, MD
  Dr. Bella Beraha, MD
  Mr. Raymond Anthony, FCPodS

<b>Title</b> <input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Dr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Rev.	<b>Surname</b>	<b>First Name</b>	<b>Initial</b>	<b>Suffix</b> <input type="checkbox"/> Jr. <input type="checkbox"/> III <input type="checkbox"/> Sr. <input type="checkbox"/> MD
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<b>Date of Birth</b>	<b>Gender</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Marital Status</b> <input type="checkbox"/> Single <input type="checkbox"/> Married
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<b>Home Address</b> House number and street: District: <input type="checkbox"/> Grand Cayman <input type="checkbox"/> Cayman Brac <input type="checkbox"/> Little Cayman  Address if abroad:	<b>Mailing Address</b> PO Box # _____ KY - _____ <b>Mobile Phone</b>  <b>Work Phone</b>  <b>Email</b>
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<b>Emergency Contact Name</b>	<b>Emergency Contact Phone</b>
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<b>Health Insurance Company</b>	<b>ID /Certificate Number</b>	<b>Plan Number</b>
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**Please hand your insurance card and ID to the receptionist**

<b>Payment Method (cheques are not accepted)</b> <input type="checkbox"/> Insurance <input type="checkbox"/> Cash <input type="checkbox"/> Debit Card <input type="checkbox"/> Credit Card	<b>Copayment Method (cheques are not accepted)</b> <input type="checkbox"/> Cash <input type="checkbox"/> Debit Card <input type="checkbox"/> Credit Card
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**CINICO PATIENTS**  
**CMO approval is an indication of medical necessity, it is NOT financial approval**  
**Please contact CINICO to determine your benefits.**

**Declaration**

I understand:

- My insurance company may only pay a percentage of my consultation and treatment fees.
- Copayment made at the time of my consultation may not be the total copayment due; that I am responsible for all sums left unpaid by my insurance company, which should be paid immediately upon notice.
- I must pay for medical supplies (e.g. orthotic insoles, splints, braces, etc.), which will not be reimbursed by my insurance company.
- A \$50.00 fee (not reimbursed by your insurance company) will be charged for failed appointments with less than 24-hour's notice.

Patient's Signature: ..... Date:.....

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