Jacqueline Azelvandre, D.O. & Associates, LLC
301 S. Milwee Street Longwood, FL 32750
Phone: (407) 339-1060 Fax: (407) 339-1081

Patient Information (Please Print):

First Name: _____ M.I.: _____ Last Name: _____

Date of Birth: _____ Social Security: _____ Sex: __Male __Female

Address: _____
Street City State Zip Code

Race: __ White __ Black/African American __Asian __American Indian Other: _____

Ethnicity: ___ Hispanic/Latino ___Not Hispanic/Latino ___Other: _____

Parents/ Legal Guardian Information (Please Print):

First Name: _____ M.I.: _____ Last Name: _____

Relation to Patient: _____

Address: _____
Street City State Zip Code

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

First Name: _____ M.I.: _____ Last Name: _____

Relation to Patient: _____

Address: _____
Street City State Zip Code

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Emergency Contact: _____ Relationship: _____

Phone Number: _____

Pharmacy: _____ Phone Number: _____

Address: _____

By signing below, I do hereby consent to any medical care which is deemed advisable or necessary by my physician and grant authority to Jacqueline Azelvandre, D.O., to administer and perform all examinations, treatments, and diagnostic procedures needed now or in the future. I guarantee payment for all services rendered. All medical benefits including major medical benefits, private insurance and any other health plan, are assigned to Azelvandre D.O. & Associates, LLC. The signature below confirms all the information provided herein is true and accurate. Photocopy of the consent is to be considered as valid as the original.

Legal Guardian Signature: _____ **Date:** _____