Patient Information Sheet

Date: ____ - ____ - ____ **Please Print**

Patient Name: ______________________ **Sex:** M F

Date of Birth: ________ **Age:** ____ **SSN:** ________ **Language:** ________

Marital Status: (Circle One) M S D W **Race:** ________ **Ethnicity:** ________

Patient Address: ______________________

City: ________ **ST:** ________ **Zip:** ________

Home Ph: ( ) ________ **Work Ph:** ________ **Cell/Pgr:** ________

Email Address: ______________________

Referring Physician: ________ **Phone:** ( ) ________

***Primary Care Physician:** ________ **Phone:** ( ) ________

***May we contact your primary care physician?** ____ **Yes** ____ **No**

Pharmacy: ________ **Pharmacy Phone:** ________

Employer: ________ **Work Address:** ________

City: ________ **ST:** ________ **Zip:** ________

Emergency Contact: ________ **Phone:** ( ) ________

(Nearest Relative - Not living at home)

Do you have insurance? (Check One) **Yes** ____ **No** ____ ***** Please present insurance card to receptionist. *****

Primary	Secondary
Name of Primary Insurance: ________	**Secondary:** ________
Policy Holder Name: ________	**Policy Holder Name:** ________
SSN: ________	**SSN:** ________
Date of Birth: ________	**Date of Birth:** ________
Policy Holder's Employer: ________	**Policy Holder's Employer:** ________
Work Ph: ( ) ________	**Work Ph:** ( ) ________
Work Address: ________	**Work Address:** ________
City/ST/Zip:	**City/ST/Zip:**

Answer the following if patient is under the age of 18

Mother's Name: ________ **SSN:** ________

Mother's DOB: ____ - ____ - ____ **Work Phone:** ________

Employer: ________ **Address:** ________

Father's Name: ________ **SSN:** ________

Father's DOB: ____ - ____ - ____ **Work Phone:** ________

Employer: ________ **Address:** ________

I authorize the following person(s) to receive my protected health information (such as family members):

Name	Relationship

Authorization for services / Please read the following and sign at the bottom of this form.

I hereby authorize payments directly to the Physician, staff, or facility for medical services rendered. I understand I am responsible for any portion of my bill not covered by my insurance company, whether as a co-pay, co-insurance, deductible, or a non-covered service. I understand office co-pays are due at the time services are rendered. I also understand all the above and state that the information provided herein is true and correct to the best of my knowledge.

Signature: ______________________ ***Date:*** ________