Patient Information Sheet

Date: ______ - ______ - ______ **Please Print**

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

Date of Birth: ______ - ______ - ______ **Age:** ______ **SSN:** ______________________

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

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

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. ***

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

Secondary: ______________________
- **Policy Holder Name:** ______________________
- **SSN:** ______________________
- **Date of Birth:** ______________________
- **Policy Holder's Employer:** ______________________
- **Work Ph:** ( ) ______________________
- **Work Address:** ______________________
- **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 forn

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:*** ______________________