PATIENT INFORMATION SHEET Date ______________

NAME: LAST ______________ FIRST ______________ MIDDLE INITIAL ______________

ADDRESS ______________

CITY ______________ STATE ______________ ZIP ______________

HOME PHONE ______________ CELL PHONE ______________

WORK PHONE ______________ EXT. ______________

E-MAIL ADDRESS ______________

PRIMARY CARE DOCTOR ______________

REFERRING PHYSICIAN ______________

DATE OF BIRTH ______________ SEX ______ (M/F) SOCIAL SECURITY ______________

MARITAL STATUS ______________

EMPLOYER NAME ______________ ADDRESS ______________

EMPLOYMENT STATUS: Full time / Part time / Non-employed

STUDENT STATUS: Full time / Part time

RESPONSIBLE PARTY: ______________ RELATIONSHIP ______________

NAME ______________

ADDRESS ______________

ETHNICITY:
□HISPANIC
□NON-HISPANIC

PRIMARY LANGUAGE SPOKEN: ______________

RACE: □ASIAN □CAUCASIAN □AFRICAN-AMERICAN □OTHER

EMERGENCY CONTACT:

NAME: ______________ RELATIONSHIP ______________

ADDRESS ______________ CITY ______________ STATE ______ ZIP ______________

HOME PHONE ______________ WORK PHONE ______________ EXT. ______________

PHARMACY NAME: ______________ PHARMACY PHONE:

PRIMARY INSURANCE ______________ POLICY HOLDER NAME ______________

POLICY HOLDER SEX (M/F) ______________ POLICY HOLDER DOB ______________

POLICY HOLDER SSN# ______________ REL. TO PATIEN ______________

ID # ______________ GROUP # ______________

SECONDARY INSURANCE ______________ POLICY HOLDER NAME ______________

POLICY HOLDER SEX (M?F) ______________ POLICY HOLDER DOB ______________

POLICY HOLDER SSN# ______________ REL. TO PATIENT ______________

ID # ______________ GROUP # ______________

I hereby authorize release of information necessary for my insurance company to process my claim. The above information is correct to the best of my knowledge.

Signed: ______________ Date: ______________

I hereby authorize payment directly to «encDocName» insurance benefits otherwise payable to me. I understand that I am financially responsible for charges not paid in a timely manner by my insurance.

Signed: ______________ Date: ______________