PATIENT INFORMATION SHEET

Acct No_____

Last Name _____First Name_____

Middle Name _____ Maiden Name _____

Home Address _____ City _____State _____ Zip_____

Mailing Address _____City _____State _____ Zip_____

SSN_____Birthdate _____ Marital Status S M D W (circle one)

Home Phone _____Cell Phone_____ Work Phone _____ Ext_____

Employer_____ _____Email _____

BELOW ARE QUESTIONS CONCERNING YOUR SPOUSE/PARENT/GUARDIAN. COMPLETE IF MARRIED OR A MINOR.

Last Name _____First Name _____MI___Relationship_____

Home Address _____City _____ State _____Zip_____

Mailing Address _____City _____State_____Zip _____

Home Phone_____Cell Phone_____ Work Phone _____ Ext _____

SSN _____Birthdate _____ Employer _____

Primary Insurance Information
Medicaid#_____Medicare#_____
Insurance Company_____
Insured(Employee)_____
Birthdate _____SSN_____
Relationship to Patient_____

Employer_____Group#_____
ID#_____Effective Date_____

Secondary Insurance Information
Medicaid#_____ Medicare#_____
Insurance Company _____
Insured(Employee)_____
Birthdate_____ SSN_____
Relationship to Patient _____

Employer_____Group #_____
ID#_____Effective Date_____

The above information is true to the best of my knowledge. PHARMACY_____

_____ _____
Signature (Patient/Guarantor) **Date**

REQUEST TO PAY BENEFITS TO PHYSICIAN: I hereby request payment be made directly to the attending physician for the medical services, if any, otherwise payable to me for the services as described.

_____ _____
Signature (Patient/Guarantor) **Date**

REQUEST TO RELEASE INFORMATION: I hereby request the attending physician to release any information to my insurance company required in the course of my examination or treatment.

_____ _____
Signature (Patient/Guarantor) **Date**

PRESENT THIS COMPLETED FORM ALONG WITH YOUR INSURANCE CARD(S) AND IDENTIFICATION CAD TO THE RECEPTIONIST.