# PATIENT INFORMATION FORM

PHARMACY # _____ DOCTOR/MIDWIFE _____

PRIMARY CARE DOCTOR _____ PRIMARY CARE DOC. PH# _____ FAX# _____

NAME _____ SEX ☐ M ☐ F

SOCIAL SECURITY# _____ BIRTHDATE_____ MARITAL STATUS ☐ S ☐ M ☐ W ☐ D

RELIGION _____AGE____ HOME PH.# (  ) _____ CELL PH: #_____

STREET ADDRESS _____ APT. _____

CITY_____ STATE _____ ZIP _____

DRIVER'S LICENSE #_____ EMAIL _____

EMPLOYER/SCHOOL_____ TITLE_____PHONE # (  ) _____

STREET ADDRESS _____ CITY _____ STATE_____ ZIP _____

SPOUSE _____ AGE _____ BIRTHDATE _____

SPOUSE EMPLOYER_____ TITLE_____PHONE # (  ) _____

STREET ADDRESS _____ CITY _____ STATE_____ ZIP _____

TRANSLATOR NEEDED ☐ YES ☐ NO PRIMARY LANGUAGE SPOKEN _____ REFERRED BY _____

**SOMEONE TO CONTACT LOCALLY IN CASE OF EMERGENCY, OTHER THAN SOMEONE LIVING WITH YOU:**

NAME _____ PHONE (  ) _____ RELATIONSHIP _____

STREET ADDRESS _____ CITY _____ STATE_____ ZIP _____

**IF PATIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING:**

FATHER'S NAME_____ MOTHER'S NAME _____

EMPLOYED BY _____ EMPLOYED BY _____

POSITION _____ POSITION _____

PHONE _____ PHONE: _____

**PRIMARY INSURANCE INFORMATION**

INSURANCE CO. _____

ADDRESS _____

CITY/STATE/ZIP _____

PHONE # _____

ID# _____

GROUP NAME OR # _____

INSURED'S FULL NAME _____

IS THIS AN EMPLOYER PLAN? _____

INSURED'S SOCIAL SEC # _____

INSURED'S D.O.B. _____

RELATIONSHIP TO INSURED _____

(Self —— Husband —— Wife —— Child —— Other )

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**GUARANTEE OF PAYMENT**

I fully understand that I am directly responsible for payment to the Physicians in this office for all medical services rendered to me. I also understand that all bills are payable and become due at the time services are rendered, unless other arrangements have been made. I agree to pay all collection costs including reasonable attorney's fees and costs in event it becomes necessary to file suit to effect payment. I authorize payments to be made directly to my doctor.

**AUTHORIZATION TO RELEASE INFORMATION**

I hereby authorize the Physicians in this office to release any information acquired in the course of my examination or treatment to my insurance company for the purpose of processing any insurance claim.

**ASSIGNMENT OF INSURANCE BENEFITS**

If insurance claims are field by this office on my behalf. I hereby authorize direct payment of any benefits to the Physicians in this office for the medical or surgical treatment received by me. In this circumstance, I understand that I am financially responsible for any charges not covered by insurance. I permit a copy of the authorization to be used in place of the original.

Signature _____ Date_____

(Patient's parent, if minor)