

PATIENT INFORMATION SHEET FOR MEDICAL RECORDS (PLEASE PRINT)

SS#: _____ - _____ - _____

Patients Full Legal Name: _____ E-mail: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ - _____ - _____ Cell: _____ - _____ - _____ Date of Birth: _____ - _____ - _____ Sex: Male Female

Employed by: _____ Work Phone: _____ - _____ - _____ Ext : _____

Marital Status: Married Single Divorced Widow

Spouse's Full Legal Name: _____ Spouse's SS#: _____ - _____ - _____

Spouse's Date of Birth: _____ - _____ - _____ Spouse's Work Phone: _____ - _____ - _____ Cell: _____ - _____ - _____

If Patient is a minor:

Who is responsible for the bill: _____ Relationship: _____

Address of Responsible party: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ - _____ - _____ Cell: _____ - _____ - _____ Work Phone: _____ - _____ - _____ Ext : _____

NAME OF PATIENTS NEAREST RELATIVE OR FRIEND TO CONTACT IN EMERGENCY

Name: _____ Relationship: _____

Home Phone: _____ - _____ - _____ Cell: _____ - _____ - _____ Work Phone: _____ - _____ - _____ Ext : _____

INSURANCE INFORMATION:

DO YOU HAVE MEDICARE? YES NO

MEDICARE #: _____

First Insurance Company: _____

Address: _____ City: _____ State: _____ Zip: _____

Policy #: _____ Group#: _____

Insured's Name: _____ Insured's Date of Birth: _____ - _____ - _____

Insured's Relationship to Patient : _____ Insured's SS#: _____ - _____ - _____

Secondary Insurance Company: _____

Address: _____ City: _____ State: _____ Zip: _____

Policy #: _____ Group#: _____

Insured's Name: _____ Insured's Date of Birth: _____ - _____ - _____

Insured's Relationship to Patient : _____ Insured's SS#: _____ - _____ - _____

HOW DO YOU INTEND TO PAY? CASH CHECK VISA MASTER CARD DISCOVER AMERICAN EXPRESS

REFERRED BY: _____

REASON FOR TODAYS VISIT: _____

HOW LONG HAVE YOU BEEN HAVING THIS PROBLEM: _____

Date: _____ Signature: _____

Date: _____ Signature: _____