Patient Information Sheet

Name: _____ DOB: _____ Gender: _____

Marital status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced Spouse's name: _____

Social security: _____ Email: _____

Home address: _____

List your phone numbers and check the number where we can leave voice messages.

☐ Home: _____ ☐ Work: _____ ☐ Cell: _____

Tell us about your job. If you are retired and you get your insurance through your former employer, provide their information below.

Occupation: _____ Employer: _____

Address: _____

Who should we contact in case of an emergency?

Emergency contact: _____ Relationship to patient: _____

Phone: _____ Are we allowed to release health information to this person? ☐ Yes ☐ No

The responsible party is responsible for any unpaid balances:

Responsible party: _____ Relationship to patient: _____

Address: _____

Which doctor referred you to us? (Leave blank if not applicable)

Referring physician: _____ Phone: _____

Address: _____

Who is your primary care physician?

Primary care physician: _____ Phone: _____

Address: _____

Write down any other physicians you see on a regular basis. We will send copies of our office notes to them and to your primary care physician unless we are instructed not to.

_____

_____

_____

Tell us about your primary health insurance. Call us if any of this information changes.

Primary insurance: _____ ID: _____

Address: _____ Phone: _____

Subscriber name: _____ Subscriber DOB: _____

Tell us about your secondary health insurance. Call us if any of this information changes.

Secondary insurance: _____ ID: _____

Address: _____ Phone: _____

Subscriber name: _____ Subscriber DOB: _____

What pharmacy do you use?

Local pharmacy: _____

Local pharmacy address: _____

Mail order pharmacy: _____

Mail order pharmacy address: _____

Prescription plan: _____ ID: _____

Answer these questions if you are a Medicare patient.

Is Medicare your primary insurance?

☐ Yes ☐ No

Do you or your spouse work for a company that provides you with health insurance?

☐ Yes ☐ No

Are you entitled to Medicare because of disability or end-stage renal disease?

☐ Yes ☐ No

Are you entitled to any benefits under the Federal Black Lung Program?

☐ Yes ☐ No

Has the Department of Veterans Affairs authorized treatment for this illness?

☐ Yes ☐ No

Answer these questions if you are here because of an auto accident or worker's compensation claim.

☐ Automobile accident ☐ Worker's compensation

Date of accident: _____

Insurance company: _____ Claim #: _____

Insurance company address: _____

Adjuster's name: _____ Phone: _____