Patient Information Sheet

Name: _____ Date of birth: _____ Gender: _____

Social Security: _____ Marital status: _____ Spouse's name: _____

Address: _____

Email: _____

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

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

EMPLOYMENT

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

Employer: _____ Occupation: _____

Address: _____

CONTACTS

Who should we contact in case of an emergency?

Emergency contact: _____ Relationship to patient: _____

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

The responsible party is responsible for any unpaid balances.

Responsible party: _____ Relationship to patient: _____

Address: _____

PHYSICIANS

Which doctor referred you to us?

Referring physician: _____ Phone: _____ Fax: _____

Address: _____

Who is your primary care physician?

Primary care physician: _____ Phone: _____ Fax: _____

Address: _____

Please complete the reverse side of this form.

INSURANCE

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

Insurance carrier: _____ ID: _____

Address: _____

Phone: _____ Subscriber name: _____ Subscriber DOB: _____

Secondary insurance: _____ ID: _____

Address: _____

Phone: _____ Subscriber name: _____ Subscriber DOB: _____

MEDICARE

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

ACCIDENT / WORKER'S COMP

Are you visiting because of an auto accident or a worker's compensation claim?

☐ Auto accident ☐ Worker's compensation

Insurance company: _____ Claim number: _____

Address: _____

Date of accident: _____ Name of adjuster / Phone: _____

PHARMACY

Where do you get your prescriptions filled?

Local pharmacy: _____

Address: _____

Mail order pharmacy: _____

Address: _____

Prescription Plan / ID: _____