Patient Information Sheet

WELCOME TO OUR PRACTICE

Please help us to serve you better by taking a few minutes to provide the following information.

PATIENT INFORMATION

Social Security Number: ______________________________

Title: _____ Last Name: ____________________ First Name: ____________________ MI: ____

Mailing Address: ______________________________

City: ____________________ State: ____________________ Zip: __________

Home Phone: ____________________ Date of Birth: ____________________

Sex: __________ Referring Physician: ______________________________

[ ] I decline to answer the following questions: **Preferred Language:**____________________

Ethnicity: [ ] Hispanic Origin [ ] Non-Hispanic Origin [ ] Unknown

Race: [ ] Am. Indian [ ] Asian [ ] Black [ ] Native Hawaiian [ ] Unknown [ ] White

Pharmacy Name: ____________________ **Pharm. Location**: ____________________

Next of Kin (Name): ____________________ Phone: __________ Relationship: __________

Marital: [ ] S-Single [ ] M-Married [ ] D-Divorced [ ] W-Widowed [ ] X-Separated

FINANCIALLY RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

Social Security Number: ____________________ Date of Birth: ____________________

Last Name: ____________________ First Name: ____________________

INSURANCE

Primary Insurance Co.: ____________________ Policy #: ____________________

Secondary Insurance Co.: ____________________ Policy #: ____________________

I authorize the release of any medical or other information necessary to process insurance claims:

Signed: ______________________________ Date: ____________________

I authorize payment of medical benefits directly to this practice for the services rendered.

Signed: ______________________________ Date: ____________________