PATIENT INFORMATION SHEET

LAST NAME: _____ FIRST NAME: _____ M.I. _____

ADDRESS: _____

CITY, STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

EMAIL: _____

DATE OF BIRTH: _____ SEX: ☐ MALE ☐ FEMALE

ETHNICITY: ☐ HISPANIC OR LATINO
☐ NOT HISPANIC OR LATINO

PREFERRED LANGUAGE: _____

MARITAL STATUS: ☐ M ☐ W ☐ S ☐ D

DRIVERS LICENSE #: _____ STATE: _____

EMPLOYED BY/RETIRED: _____ BUSINESS ADDRESS: _____

EMERGENCY CONTACT NOT LIVING WITH YOU: _____

RELATIONSHIP: _____ PHONE: _____

PRIMARY INSURANCE: _____

INSURANCE MAILING ADDRESS: _____

ID#: _____ GROUP# _____ CO-PAY: $_____

SECONDARY INSURANCE: _____ ID#: _____

INSURANCE MAILING ADDRESS: _____

REFERRED BY: _____ PRIMARY DR.: _____ PHONE: _____

PHARMACY: _____ PHONE: _____

PHARMACY LOCATION: _____

REASON FOR TODAY'S VISIT: _____

I understand I am financially responsible for all charges & copays whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I assign directly to your office all benefits and authorize the use of this signature on all insurance submissions, whether manual or electronic.

PATIENT SIGNATURE: _____ DATE: _____