PATIENT INFORMATION SHEET

NAME (LAST) ______________________ (FIRST) ____________________ (INITIAL) ________
(*As Listed With Your Insurance)*
PHONE (HOME) _________________________ (WORK) _______________________________

ADDRESS:
STREET: ____________________________
CITY: _____________ ________________
STATE: ____________ZIP:_____________

MAILING ADDRESS: (IF DIFFERENT)
PO BOX/STREET __________________
CITY: ____________________________
STATE: ___________ ZIP: __________

Patient's Date of Birth: _____________________
Patient's Social Security #:___________________
Patient's Occupation:____________________
Patient's Legal Status: (circle one) S • M • Sep • D • W

Subscriber's Employer:__________________
Subscriber's Employer
Address:___________________________
____
Subscriber's Soc. Sec. #______________

Emergency Contact: _____________________________ Phone: _______________________
Relationship to Patient:____________
Nearest of Kin: _________________________________ Phone: _______________________
(If under 18 years) Relationship to Patient:____________

Person To Receive Bill: __________________________ Phone:__________________________
Address ____
(If different from above.)

Primary Care Physician: ____
Alergies:____

HEALTH INSURANCE:

Blue Shield: Cert # ____________________________
State: ____________________________

Subscriber Name: _________________
Group #:________________________
(If on insurance card.)

Name of Your Insurance: ______________________
Insurance Address: ______________________
*(If on back of card.)*_________________________

Medicare:# _______________________
Medex:# _________________________

Subscriber: __________________________________

Patient's ID#: ___________________________________
(On insurance card)

Group #: ________________________
(If on insurance card.)

No Insurance (Circle if applicable)

I hereby authorize my insurance benefits to be paid directly to ____________________ for the medical services rendered. I also authorize ________________________ to release any information necessary to process this claim.

Signature: __________________________ Date: ______________________________