

PATIENT INFORMATION SHEET

Patient Last Name: _____ First: _____ Initial: _____ Date of Birth: _____
Address: _____ Sex: _____
City: _____ County: _____ State: _____ Zip: _____ HomePhone: _____
Parent's Marital Status: Married _____ Single _____ Divorced _____ Separated _____ Ethnicity(race) _____

Mother's Name: _____ Father's Name: _____
Work Phone: _____ Work Phone: _____
Cell Phone: _____ Cell Phone: _____
Employer: _____ Employer: _____

Responsible Party: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip: _____
Relationship to Patient: _____
In Case of Emergency Contact: _____ Relation: _____ Phone: _____
Primary Email Address: _____

Primary Insurance Company: _____ Phone: _____
Claim Address: _____ City: _____ State: _____ Zip: _____
Policy Holder Name: _____ Relationship to Patient: _____
Policy # _____ Group: _____ Date of Birth: _____

Secondary Insurance Company: _____ Phone: _____
Claim Address: _____ City: _____ State: _____ Zip: _____
Policy Holder Name: _____ Relationship to Patient: _____
Policy # _____ Group: _____ Date of Birth: _____

Primary Physician or Pediatrician (not group name) _____ Phone# _____

Address: _____ City: _____ State: _____ Zip: _____

Allergies: _____ Does Anyone in Your Family Smoke? _____ Who? _____

Reason For Visit: _____

I hereby authorize the above physician to obtain records from other sources as may be needed in the treatment of this patient. I hereby authorize the release of information concerning this patient's treatment to other physicians involved in the care and treatment of this patient. I hereby authorize the release of information to the insurance company as needed to file the charges incurred by this patient. I hereby authorize payment of insurance benefits otherwise due to me to be made directly to the above physician or hospital. I understand that I am responsible for any amount not covered by the insurance company. A copy of this information shall be valid as the original. I have received a copy of the GPPA's Notice of Privacy Practices.

Signature of Parent or Responsible Party Date Patient #