PATIENT DATA SHEET

Name: ____

Birth Date: ____________________ Social Security Number: ____________________

Marital Status: Single Married Separated Divorced Widowed Life Partner

Race: ____________ Ethnicity: ____________ Preferred Language: ____________

Country of Origin: ____

Patient's Address: ____

City: ______________ State: ______________ Zip: ______________

Home Phone: ____________ Cell Phone: ____________ Work Phone: ____________

Patient's Employer: ____________________ Position: ____________________

Email Address: ____

Name of Primary Insurance: ____

Subscriber's Name: ____

Social Security Number: ____________________ Birth Date: ____________________

Relationship to Patient: ____________________ Policy Effective Date: ____________________

ID # ____________________ Group # ____________________

Name of Secondary Insurance: ____

Subscriber's Name: ____

Social Security Number: ____________________ Birth Date: ____________________

Relationship to Patient: ____________________ Policy Effective Date: ____________________

ID # ____________________ Group # ____________________

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Whom should we contact in case of an emergency? ______________________________

His/Her daytime phone number: ______________________________

His/Her relationship to you: ______________________________

____

Is our clinic your primary care provider? ☐ Yes ☐ No

If not, who is? ____

____

How did you hear about us? Yellow Pages Insurance Radio Internet Advertisement

Friend/Family (Name) ____________________ Physician (Name) ____________________

I VERIFY THE ACCURACY OF THE INFORMATION AND AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND ASSIGN PAYMENT DIRECTLY TO THE PHYSICIAN FOR THE SERVICES DESCRIBED.

PATIENT'S SIGNATURE: ____________________ **DATE:** ____________________