Patient Information Sheet

MRN (Epic) _________________ **Patient Information**

Name ____ Social Security # _________________ Sex: M F
Last First Middle

Date of Birth _______________ other known name(s) ____

Mailing Address _____________________________________ _____________________ ________________ ________
City State Zip

County ______________________ Country ______________________ □ permanent address □ temporary address

Home phone _______________________ Work phone ____________________ Mobile phone _____________________

Email address ____ Language _____________________________________

Person outside of household to contact in case of emergency or in case we must reschedule an appointment for you.

Name ____ Phone #'s ___________________________ Relationship ______________

Marital Status: (circle one)
Married
Divorced
Legally Separated
Single
Widowed
Significant Other
Unknown
Other

Ethnicity: (circle one)
Hispanic or Latino
Not Hispanic or Latino
Unknown
No Answer

Race: (circle one)
American Indian or Alaska Native
Asian
Black or African American
Native Hawaiian or Other Pacific Islander
White or Caucasian

Primary Care Physician____

Responsible Party Information (Guarantor)

Name ____ Social Security # _________________ Sex: M F
Last First Middle

Date of Birth ________________ other known name(s) ____

Mailing Address _____________________________________ _____________________ ________________ ________
City State Zip

County ______________________ Country ______________________ Relationship to patient ________________________

Home phone _______________________ Work phone ___________________ Mobile phone _________________________

Employer ____

Employer address ________________________________ ______________________ __________________ ____________
City State Zip

Employer phone _________________________ Employer fax __________________________

Employment Status: (circle one) disabled full time part time not employed on active military duty retired
Self-employed student full-time student part-time unknown

Subscriber Information (if different from Guarantor)

Name ____ Social Security # ________________ Sex: M F
Last First Middle

Date of Birth _______________ other known name(s) ____

Mailing Address ___________________________________ ____________________ _______________ ________
City State Zip

County _____________________ Country _____________________ Relationship to patient_______________________

Home phone ______________________ Work phone __________________ Mobile phone ________________________

Employer ____

Employer address ______________________________ _____________________ _________________ ___________
City State Zip

Employer phone ________________________ Employer fax _________________________

Employment Status: (circle one) disabled full time part time not employed on active military duty retired
Self-employed student full-time student part-time unknown

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Insurance Information

(Primary Coverage)

Insurance Company _____________________________

Ins Address ____________________________________

City ______________________ State _______________

Zip ____________ Phone __________________________

Relationship to Patient ___________________________

Insurance ID # _________________________________

Effective Date __________________________________

Group # _______________________________________

Name on Card __________________________________

Covered Through: (circle one) current employer retirement
Cobra/continuation of benefits
Other __________________

Employer Size: (circle one) 1-19 employees
20-99 employees
100+ employees

(Secondary/Supplemental Coverage)

Insurance Company ______________________________

Insurance Address _______________________________

City _______________________ State ______________

Zip ___________ Phone ___________________________

Relationship to Patient ____________________________

Insurance ID# __________________________________

Effective Date ___________________________________

Group # ____

Name on Card __________________________________

Covered Through: (circle one) current employer retirement
Cobra/continuation of benefits
Other __________________

Employer Size: (circle one) 1-19 employees
20-99 employees
100+employees

I understand, as a service to our patients, we provide a courtesy appointment reminder call and / or text and possibly other important calls that may be placed using a pre recorded message or autiodialer. By providing your cell phone number, you consent to receiving such calls/texts at this number.

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I understand that this information serves as a basis for planning my care and treatment, a means of communication among the many healthcare professionals who contribute to my care, a source of information for applying my diagnosis and surgical information to my bill, a means by which a third-party payer can verify that services billed were actually provided and a tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right to object to the use of my health information for directory purposes, to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the organization is not required to agree to the restrictions requested and to revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

Signed____ Date ___________________________