PATIENT DEMOGRAPHIC INFORMATION

TODAYS' DATE CHART _____

PATIENT INFORMATION

Full Name: Sex: n Male 0 Female
Last First M Birthdate: _____/_/_
Address: Social Security#:

Home Phone #:

City State Zip

Pharmacy Name:

Marital Status: :1 Single c1 Married [3 Divorced Pharmacy #:

Employer: Occupation: Work Phone #
Contact in case of emergency: Contact Phone #

GUARANTOR INFORMATION (IF **PATIENT** IS **UNDER** 18 **YEARS** OLD)

Full Name: Sex: [3 Male a Female
Last First M Birth date: I /
Address: Social Security#:

Home Phone #:

City State Zip

Patient relationship to Guarantor: Drivers License#:

Employer: Work Phone #:

INSURANCE INFORMATION

Primary Insurance: Relation to Patient:
Address: Policy #:

Group #:

City State Zip

Policy Holders Name: SS#:
Policy Holders Birth date:
Policy Holders Employer: Work Phone#:
Employers Address:

SECONDARY INFORMATION

Primary Insurance: Relation to Patient:
Address: Policy #:

Group #:

City State Zip

Policy Holders Name: SS#:
Policy Holders Birth date:
Policy Holders Employer: Work Phone#:
Employers Address:

CONSENT TO **TREAT, ASSIGNMENT** OF **BENEFITS,** AND **RELEASE** OF **INFORMATION** TO **INSURANCE COMPANY**

[ ] l consent to treatment necessary for the patient indicated on this form. i understand this facility may employ Physician extenders. **>** '

[1 l hereby authorize payment of medical benefits directly to the att'endingphysician for services rendered.
Authorization is hereby granted to release information as may be necessary to process and complete my claim.
i understand I am financially responsible for this account. ~

Date: Signature: