Patient Information Sheet

Patient Name:_____
First M.I. Last

Email:_____

Patient Street Address: _____
Street City State Zip Code

Home Phone: ( ) _____ __ **Cell Phone:** ( ) _____ __

Emergency Contact _____
Contact Name Number Relationship

DOB: _____/_____/_____ **SSN:**_____-_____-_____ **Sex:** _____

Marital Status: (Circle One) Single Married Other Child Widow(er)

Ethnicity: (Circle One) Hispanic Non-Hispanic Other

Race: (Circle One) American Indian/Alaska Native Asian African American/Black Caucasian Native Hawaiian Other Pacific Islander Other

Language Spoken: (Circle One) Portuguese Spanish English

Employment Status: (Circle One) Employed Student (full-time) Student (part-time) Retired-Date_____

Who is responsible for the bill? (SELF OR CUSTODIAN OF CHILD)

Name: _____ **Relationship to Patient:** _____

DOB: _____/_____/_____ **SSN:** _____-_____-_____

Responsible Party's Address: _____
Street City State Zip Code

*****PLEASE NOTE: WE DO NOT FILE CLAIMS FOR WORKER'S COMPENSATION OR ANY MOTOR VEHICLE RELATED INJURIES Please check with your employer or we can give you the name of an office that can handle these services.*****

Primary Insurance: _____
Insurance Name ID# Group#

Subscriber: _____ **Relationship to Patient:** _____

DOB: _____/_____/_____ **SSN:** _____-_____-_____ **CO-PAY Amount:**_____

Primary Insurance Street Address: _____
Street City State Zip Code

Secondary Insurance: _____
Insurance Name ID# Group#

Subscriber:_____ **Relationship to Patient:**_____

DOB: _____/_____/_____ **SSN:** _____-_____-_____

Secondary Insurance Street Address: _____
Street City State Zip Code

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize Release of any medical information necessary to process this claim and authorize payment of medical benefits to Michael S. Rogers MDPA for services rendered.

Signature:_____ **Date:**_____