Patient Information Sheet

Patient Name _____Nickname (if any) _____
Street Address _____
City/State/Zip _____
Mailing Address (if different) _____CSZ _____
Home Phone (___) _____ Cell Phone (___) _____
Sex: M or F Dateof Birth _____ Soc Sec No. _____

Marital Status (circle): Single Married Divorced Widowed Separated

Patient's Employer: _____ How Long _____
Employer Address: _____CSZ_____ Work Phone (___)_____
****

Family Information

*Mother Name: _____ Cell Phone (___) _____
Date of Birth _____ Soc. Sec. No. _____
Employer Name: _____
Employer Address _____CSZ_____ Work Phone (___) _____
*Father Name _____ Cell Phone (___) _____
Date of Birth _____ Soc. Sec. No. _____
Employer Name _____
Employer Address _____CSZ _____ Work Phone (___)_____
*Spouse Name _____ Cell Phone (___) _____
Date of Birth _____ Soc. Sec. No. _____
Employer Name: _____
Employer Address: _____CSZ _____Work Phone (___) _____
*Please list all other family members: _____
_____
Who do we notify in case of an emergency? _____
Home Phone (_____) _____ Cell Phone (___) _____ Work Phone (_____) _____
May we discuss medical issues with this person?
****

Insurance Information

Primary Ins. Co. Name _____ Secondary Ins. Co. Name _____
Subscriber Name: _____ Date of Birth _____ Soc. Sec. No. _____
Address if not listed above: _____CSZ_____
InsID No. _____ ID. No. _____
Ins Group No. _____Group No. _____
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Please Read and Sign:

I authorize Powhatan Family Physicians, LTD. to render medical service to my child/myself, listed above, and to release any information regarding medical history, diagnosis, and treatment to the insurance company regarding any services rendered. I authorize payment directly to Powhatan Family Physicians, LTD for services rendered and understand and agree that health and accident policies are an arrangement between the insurance carrier and the subscriber and that any unpaid balance is the responsibility of patient or responsible party or Parents/guardians for minor children. The balance will be due and payable if insurance has not paid within 45 days or 60 days if Workers Compensation. If my account is turned over to an attorney for collection, I will be responsible for all attorney fees , any accrued interest, and all court costs incurred**. I have read and understand the above.**

Signature _____ *Date* _____ *Witness Initials* _____