PATIENT INFORMATION SHEET

PATIENT INFORMATION

Patient Name: _____,_____Birthdate_____

Address: _____

Zip: _____ City:_____State: _____

Home number: (_____) _____ Cell Phone: _____

Sex: Male / Female (Circle one) Patients SS#: _____

Referred by: _____ Pediatrician: _____

Address: _____ Address: _____

City: _____ST:____Zip:_____ City: _____ST:____Zip:_____

Phone: (_____) _____ Phone: (_____) _____

Preferred Contact & Phone: _____

GUARANTOR INFORMATION

Name of mother: _____ Name of father: _____

Address: _____ Address: _____

City: _____ City: _____

State: _____Zip: _____ State: _____Zip: _____

Home number: (_____) _____ Home number: (_____) _____

SS#: _____ SS#: _____

Employer: _____ Employer: _____

Work number: (_____) _____ Work number: (_____) _____

Birthdate _____ Birthdate _____

INSURANCE INFORMATION

Is the patient covered by MEDICAID ? YES _____NO ____

Primary insurance: _____ Secondary insurance: _____

Phone number: (_____) _____ Phone number: (_____) _____

Policyholder's name: _____ Policyholder's name: _____

Group number: _____ Group number: _____

Policy number: _____ Policy number: _____

ASSIGNMENT AND RELEASE: I hereby assign my insurance benefits to be paid directly to Sunset Clinic PA. I understand that I am financially responsible for any non-covered services, collection agency fees and or attorney fees. I also authorize the provider to release any information required to process this claim.

Signed: _____Date: _____