# PATIENT INFORMATION RECORD

## PATIENT INFORMATION (Please Print)

| Patient's Name | Sex M F | Marital Status S M W DI SEPI | Date Of Birth | Age | Social Security Number |
|---|---|---|---|---|---|
| Street Address Apt #. | City and State | | Zip Code | | Home Phone No. |
| Patient's Employer | Occupation | | How Long Employed? | | Business Phone No. |
| Employer's Street Address | City and State | | Zip Code | | Cell Phone No. |
| Drug Allergies | Race C H B Asian Am. Indian Other | | | | Driver's License Number and State |

| Spouse's Name | Date Of Birth | Social Security Number | |
|---|---|---|---|
| Spouse's Employer | Occupation | How Long Employed? | Business Phone No. |
| Employer's Street Address | City and State | Zip Code | Cell Phone No. |
| Has A Member of Your Family Been Here Before? | Name(s) and Age(s) of Children | | |

## INSURANCE INFORMATION

| Do You Have Insurance? Yes No IF YES, PLEASE PRESENT INSURANCE CARD TO RECEPTIONIST | | | |
|---|---|---|---|
| Name of Policy Holder | Date of Birth | Policy Number (ID #) | Group Number |

## IF MINOR OR STUDENT, PLEASE FILL INFO BELOW

| Mother 's Name | Date of Birth | Street Address, City, State, Zip Code | Social Security Number |
|---|---|---|---|
| Mother's Employer | Occupation | Home Phone No. | Business Phone No. |
| Father's Name | Date of Birth | Street Address, City, State, Zip Code | Social Security Number |
| Father's Employer | Occupation | Home Phone No. | Business Phone No. |

**I understand that payment for all services rendered (Cash/Visa/MasterCard/Discover) is requested at the time of service.**

Authorization to pay benefits to physician: I hereby authorize payment directly to the undersigned physician of the surgical and/or medical benefits, if any, otherwise payable to me for his service as described below by not to exceed the reasonable and customary charge for those services

To the best of my knowledge, this information is correct and I hereby authorize The Family Doctor disclosure of information, consent for treatment, payment, and healthcare operations.

| Signature | Date | Referred By |
|---|---|---|
| | | |