GENERAL PATIENT INFORMATION

1. Today's Date: _____ 2. Arrival Time: _____
3. New Patient? Yes ____ No____ 4. If No, date or year last seen: _____
5. Last Name: _____
6. First Name: _____ 7. Middle Initial: _____
8. Male _____ Female _____ 9. Date of Birth: _____
10. Social Security #: _____
11. Home Address: _____
12. City: _____ 13. State: _____ 14. Zip Code: _____
15. Home Telephone: _____ 16. Cell #: _____ 17. Work #: _____
18. Emergency Contact: Name of person not living with you: _____
19. Relationship: _____ 20. Telephone: _____

INSURANCE INFORMATION

1. Last Name of Primary Cardholder (If Different from Above): _____
2. First Name: _____ 3. Middle Initial: _____
4. Male _____ Female _____ 5. Date of Birth: _____
6. Social Security #: _____
7. Occupation: _____
8. Name of Employer: _____
9. Employer Address: _____
10. City: _____ 11. State: _____ 12. Zip Code: _____
13. Employer Telephone: _____
14. Insurance Company Name: _____
15. Insurance I.D. #: _____ Group #: _____

I AGREE TO PAY SUNNYSIDE MEDICENTER FOR MY MEDICAL SERVICES. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM, INCLUDING REVIEW ACTIVITIES RELATED TO MY PHYSICIAN'S PARTICIPATION WITH MY HEALTH PLAN.

X_____ Date _____

IN THE EVENT MY INSURANCE IS NOT IN EFFECT AT THE TIME OF SERVICE, THE CLAIM IS DENIED OR THE SERVICE IS NOT COVERED BY INSURANCE, I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR THE DEBT. I UNDERSTAND I AM ALSO RESPONSIBLE FOR MY CO-PAYMENT AND DEDUCTIBLE.

X_____ Date _____