

# STEINER RANCH PRIMARY CARE

## PATIENT INFORMATION

Please Circle: Mr. Mrs. Ms. Jr. Sr.

Patient's Name Last \_\_\_\_\_ First \_\_\_\_\_

Middle \_\_\_\_\_ Wishes to be called \_\_\_\_\_

Please Circle: Married Single Divorced Widowed Separated

Social Security Number \_\_\_\_-\_\_\_\_-\_\_\_\_ Female Male Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

E-mail Address: \_\_\_\_\_

Phone Numbers: Daytime \_\_\_\_\_ Evening \_\_\_\_\_

Cellular \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Employment Status: Please circle: Employed Retired Self Employed Unemployed

Full-time Student Part-time Student

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Referred by \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Emergency Contact Relationship to Patient \_\_\_\_\_

## FINANCIAL RESPONSIBLE PARTY

Name Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Phone Numbers Daytime \_\_\_\_\_ Evening \_\_\_\_\_

Address \_\_\_\_\_ Social Security Number \_\_\_\_-\_\_\_\_-\_\_\_\_

\_\_\_\_\_

## INSURED PARTY INFORMATION

Insured Party Name Last \_\_\_\_\_ First \_\_\_\_\_

Social Security Number \_\_\_\_-\_\_\_\_-\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Phone Numbers Home \_\_\_\_\_ Cell \_\_\_\_\_

## PRIMARY INSURANCE

Name \_\_\_\_\_ Phone \_\_\_\_\_

## SECONDARY INSURANCE

Name \_\_\_\_\_ Phone \_\_\_\_\_

**WHOM TO CONTACT**

I hereby give permission to Steiner Ranch Primary Care to disclose and discuss any information related to my medical condition(s) to/with the following family member(s), other relative(s) and/or close personal friend(s):

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone Number \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone Number \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone Number \_\_\_\_\_

I do not wish to give permission for additional family members, relatives or close personal friends to have access to any information regarding my medical condition(s)

**I WISH TO BE CONTACTED AT:** Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Other #: \_\_\_\_\_

- Ok to leave messages at home.       Yes or  No
- Ok to leave messages on my cell.       Yes or  No
- Ok to mail to my home address.       Yes or  No

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical information.

Signature of Patient or Legal

Representative \_\_\_\_\_ Date \_\_\_\_\_