

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 _____