Patient Information Sheet

Patient Name ____ Age __________Birthdate_____________
(last) (First) (MI)
Prefered Name _________________________ Marital Status S M D W O Gender M F
Address (Mailing)____
City: _____________________________State _________ Zip ____________
email____
Home phone # ______________________ cell phone # _____________________work # ____________________
Occupation________________________________
Who may we contact in case of emergency?____
Relationship _______________________________________ phone # _____________________________________
How did you hear about us?____

Insurance Information

Subscriber (whose job provides the plan)?____
(Last) (First) (MI)
Subscriber's date of birth____________________________________
Insurance co. ____ group # ____________________________
Secondary Insurance?_______________________________________ group # ____________________________

Authorization to bill insurance benefits / consent for treatment

If required, I hereby authorize payment directly to the Nurse Practitioner responsible for my care. I understand that I am financially responsible for all fees incurred and for fees not covered by insurance. I authorize release of my medical information to my third party payor in order to obtain payment I hereby authorize Promise Medical to release any medical information required for my examination and treatment. I understand that payment is expected at rendering of services unless other arrangement have been made. I hereby also consent to medical treatment for my present condition or injury, and for any illness or injury incurred at any time after date noted below.

Signature of responsible party ____
Printed name ____