



PATIENT INFORMATION

PATIENT ACCOUNT \_\_\_\_\_ DATE \_\_\_\_\_

PATIENT NAME \_\_\_\_\_  
LAST FIRST MIDDLE INITIAL

DATE OF BIRTH \_\_\_\_\_ SEX \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_

SOCIAL SECURITY NUMBER \_\_\_\_\_

PATIENT ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

PATIENT EMPLOYER \_\_\_\_\_

ADDRESS \_\_\_\_\_

- EMPLOYMENT STATUS (CIRCLE ONE)
- 1. FULL TIME
  - 6. ACTIVE DUTY
  - 2. PART TIME
  - 7. UNKNOWN
  - 3. NOT EMPLOYED
  - F. FULL-TIME STUDENT
  - 5. RETIRED
  - P: PART-TIME STUDENT

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IF PATIENT IS A MINOR:

MOTHER'S NAME \_\_\_\_\_

FATHER'S NAME \_\_\_\_\_

OTHER CHILDREN IN FAMILY \_\_\_\_\_

RESPONSIBLE PARTY/INSURANCE SUBSCRIBER

RESPONSIBLE PARTY: \_\_\_\_\_

SEX \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ SOCIAL SECURITY \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

RELATIONSHIP TO SUBSCRIBER (CIRCLE ONE)

- HUSBAND
- SON
- INDIVIDUAL
- OTHER
- WIFE
- DAUGHTER
- GUARDIAN

RESPONSIBLE PARTY EMPLOYER \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PRIMARY INSURANCE \_\_\_\_\_  
GROUP NUMBER \_\_\_\_\_ ID NUMBER \_\_\_\_\_  
SUBSCRIBER \_\_\_\_\_  
DATE OF BIRTH \_\_\_\_\_ SOCIAL SECURITY \_\_\_\_\_  
INSURANCE ADDRESS \_\_\_\_\_  
EFFECTIVE DATE \_\_\_\_\_

SECONDARY INSURANCE \_\_\_\_\_  
GROUP NUMBER \_\_\_\_\_ ID NUMBER \_\_\_\_\_  
SUBSCRIBER \_\_\_\_\_  
DATE OF BIRTH \_\_\_\_\_ SOCIAL SECURITY \_\_\_\_\_  
INSURANCE ADDRESS \_\_\_\_\_  
EFFECTIVE DATE \_\_\_\_\_

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WHOM MAY WE CONTACT IN CASE OF EMERGENCY? \_\_\_\_\_  
PHONE NUMBER \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

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HOW DID YOU CHOOSE OUR CLINIC FOR YOUR CARE?  
\_\_\_\_ FRIEND \_\_\_\_ YELLOW PAGES \_\_\_\_ REPUTATION \_\_\_\_ HEALTH PLAN  
\_\_\_\_ PHYSICIAN \_\_\_\_ BROCHURE  
NAME OF REFERRING PHYSICIAN \_\_\_\_\_

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**RECORDS RELEASE:** I authorize Southern Metro Medical Clinics (SMMC) to disclose and furnish copies of any information, including medical and billing information, information related to substance abuse, mental health, HIV/AIDS, or other sensitive issues, relating to my care at SMMC to any person (this may include insurance companies, the responsible party named and immediate family on behalf of myself and/or dependents) or health care provider SMMC believes to be involved in my care.

DATE \_\_\_\_\_ SIGNED \_\_\_\_\_

**ASSIGNMENT OF BENEFITS:** I hereby authorize payment of medical or dental benefits to Southern Metro Medical Clinics for services rendered to myself and/or dependents. I permit a copy of this authorization to be used in place of the original.

DATE \_\_\_\_\_ SIGNED \_\_\_\_\_

**CONSENT FOR TREATMENT:** I voluntarily consent to diagnostic procedures and medical treatment by members of Southern Metro Medical Clinics, as necessary in my provider's professional judgement. I am aware that the practice of medicine is not an exact science and acknowledge no guarantees can be made about the result of such treatment.

DATE \_\_\_\_\_ SIGNED \_\_\_\_\_

**MY MEDICAL CARE:**

\_\_\_\_ MAY BE DISCUSSED WITH THE FOLLOWING RELATIVES/FRIENDS:

Name _____	Relationship _____
Name _____	Relationship _____
Name _____	Relationship _____

\_\_\_\_ I do not wish my medical care to be discussed with any friends or relatives  
\_\_\_\_ I give permission to the clinic to leave messages on my voice mail/answering machine and/or place of business.

DATE \_\_\_\_\_ SIGNATURE \_\_\_\_\_

**MEDICAL AUTHORIZATION:** I request the payment of authorized Medicare benefits to be made to me, or on my behalf, to Southern Metro Medical Clinics for any services furnished me by the physician and/or clinic. I authorize any holder of hospital or medical information about me to be released to the health care financing administration and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

DATE \_\_\_\_\_ SIGNATURE \_\_\_\_\_