

PATIENT INFORMATION

Name: _____ Patient ID#: _____ Sex: []M []F
Address: _____ Date of Birth: _____ Age: _____
City,State,Zip: _____ Driver's License#: _____
Primary Phone: _____ Home Social Security #: _____
Alt Phone: _____ Work Marital Status: [] Married [] Single [] Divorced
Mobile/Pager Phone: _____ Veteran Status: _____ Veteran _____ Non-Veteran
Race: ___ American Indian/Alaskan Native ___ White/Caucasian
_____ Hispanic ___ Black/African American ___ Asian
_____ Native Hawaiian or other Pacific Islander ___ Hispanic

PATIENT EMPLOYMENT INFORMATION

[] Employed [] Retired [] Unemployed [] Other

Employer's Name: _____
Employer's Phone: _____
Occupation: _____

EMERGENCY CONTACTS

Name	Relationship	Phone
_____	_____	_____
_____	_____	_____

RESPONSIBLE PARTY (if patient is under 18 years of age)

Name: _____
Address: _____
City,State,Zip: _____

Employer: _____
Home Phone: _____
Work Phone: _____
SSN: _____
Date of Birth: _____

PRIMARY INSURANCE

Insurance Company Name: _____
ID#: _____
Group/Policy#: _____
Subscriber's Name: _____
Subscriber's Phone #: _____
Relationship to Patient: _____
Subscriber's Employer: _____
Subscriber's SS #: _____
Subscriber's Date of Birth: _____

SECONDARY INSURANCE

Insurance Company Name: _____
ID#: _____
Group/Policy#: _____
Subscriber's Name: _____
Subscriber's Phone #: _____
Relationship to Patient: _____
Subscriber's Employer: _____
Subscriber's SS#: _____
Subscriber's Date of Birth: _____

WORK RELATED INJURY

Only applicable if injury is related to work or auto accident

Insurance Carrier Name: _____ Address: _____
City,State,Zip: _____ Phone: _____
Claim Number: _____ Date of Injury: _____ Employer @
time of Injury _____

I assign directly to Sunshine Community Health Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the clinic to release all information necessary to secure the payment of benefits. I understand that my account should be paid within 30 days. I also understand that should my account be referred to an attorney or collection agency, I shall pay the attorney's fee and/or collection agency expenses. All delinquent patient accounts may be charged interest at the legal rate. I authorize the use of this signature on all insurance submissions.

Patient/Guardian Signature

Relationship

Date