PATIENT INFORMATION

Last Name ______________________________ First Name ______________________________ MI ___________

Address ____ City _______________ State _____ Zip Code _______

SSN _______-_____-________ Phone #(________)_______-____________ Date of Birth ______/______/________

Marital Status: S M W D Occupation ____________________________________ Retired: Yes No

RESPONSIBLE PARTY (If applicable)

Last Name ______________________________ First Name ______________________________ MI ___________

Address ____ City _______________ State _____ Zip Code _______

SSN ________-______-_________ Phone #(_________)________-____________ Date of Birth ______/______/________

Relationship to Patient ________________________________ Email ______________________________________

EMERGENCY CONTACT

Last Name ______________________________ First Name ______________________________ MI ___________

Phone #(_________)________-____________ Relationship to Patient _____________________________________

PRIVATE HEALTH INSURANCE INFORMATION

Primary Insurance Carrier __________________________________ Policy ID # ____________________________

Group # ___________________________ Insured's Name ____

Patient Relationship to Insured: [ ] Self [ ] Spouse [ ] Child [ ] Other __________________________________

Secondary Insurance Carrier __________________________________ Policy ID # _________________________

Group # ___________________________ Insured's Name ____

Patient Relationship to Insured: [ ] Self [ ] Spouse [ ] Child [ ] Other __________________________________

I do hereby consent to and authorize the performance of all treatments, procedures and medical services by the staff of Senior Care Medical Associates, a medical group Inc., which they may deem advisable. I hereby certify that, to the best of my knowledge, all statements contained hereon are true.

X ____ ________________________________

Patient signature *or legal/personal representative* Date

____ ________________________________

Patient or legal/personal representative name (PRINT) Relationship to Patient