



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