



PATIENT INFORMATION (PLEASE PRINT CLEARLY)

Legal Name of Patient (Last) (First) (MI) Birth Date

Age: Sex: Male Female Social Security #:

Home Address: (Street) (City) (State) (Zip)

Mailing Address: (Street) (City) (State) (Zip)

Phone in order of preference: 1) 2) 3) Home Cell Work

E-mail address:

Preferred language: Need interpreter: Yes No

Marital Status: Married Single Divorced Widowed Other Religion

Ethnicity: Hispanic or Latino Origin Not Hispanic or Latino Origin Race

Allowed Communication: Do not Contact Mail Phone MyChart Primary Care Physician:

Referring Physician: Phone #:

Emergency Contact: (Name) Home Phone # (Emergency Contact)

Relationship to Patient: Cell Phone # (Emergency Contact)

Patient Employer: Work Phone#: Ext.

Custodial Parent: (If Patient is Child) (Name) Birth Date: SSN#

Address: City: State: Zip:

Home #: Employer: Wk Phone #: Ext:

Is this a work related injury or illness? Yes No If yes, please provide worker's comp information below.

Insurance Information: We will need a copy of the insurance card in order to file a claim.

Primary Insurance Coverage: Policy #:

Group #: Insured Name:

Male Female DOB: SSN#:

Relationship to Patient: Primary Insured Employer:

Secondary Insurance Coverage: Policy #:

Group #: Insured Name:

Male Female DOB: SSN#:

Relationship to Patient: Primary Insured Employer:

Third Insurance Coverage: Policy #:

Group #: Insured Name:

Male Female DOB: SSN#:

Relationship to Patient: Primary Insured Employer:

I authorize SSM Health Medical Group, including any collection agency or debt collector hired by SSM Health Medical Group to check my credit and employment history, obtain a copy of my consumer report and obtain personal information from any consumer reporting agency or any other person or entity in possession of such information. I also authorize SSM Health Medical Group, or through its contracted debt collection of amounts owed for said services, using an automatic telephone dialing system or prerecorded voice at the telephone number(s) I provided, including a telephone number assigned by a cellular telephone service or any service for which I am charged for the call. In addition, I consent to and agree that any call between SSM Health Medical Group and I may be monitored and/or recorded for any purpose.

Patient/Custodial parent Signature:

I hereby apply for treatment by the physicians of this practice and or their assistants. I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf and I assign the benefits payable to which I am entitled to this practice. I understand that payment is due at the time of service and that I am financially responsible for all charges, whether or not paid by insurance.

Signature: Date: