

PATIENT INFORMATION

Name: _____ Date of Birth: _____ Sex: M F

Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ Work Phone #: _____

Cell Phone #: _____ Social Security #: _____

Married: Yes No Name of Spouse: _____

Name of Children who are patients at our office: _____

Email address: _____ @ _____ . _____

Insurance Company: _____ Phone #: _____

Policy Number: _____ Group Number: _____

Name of Primary Insured: _____ Birth Date of Primary Insured: _____

Social Security # of Primary Insured: _____ Primary Insured's relationship to you: Self Spouse Parent

Place of Employment of Primary Insured: _____

Do you authorize Dr. Sloan and his office to **release medical information to your spouse**? Or other? _____
If Yes, sign here: _____ Date: _____

- I understand that Dr. Sloan and his office will keep my information in strict confidence and understand that the Privacy Policies of the Practice are posted in the office and I have received the Notice of Privacy Practices and have been provided an opportunity to review it.
 - I hereby authorized Dr. Sloan and his office to release my medical information to physicians/providers that he refers me to in order to be treated medically.
 - I hereby authorize Dr. Sloan and his office to furnish medical information to insurance carriers concerning my illness, treatment, and tests.
 - I hereby assign payments for medical treatment rendered to my dependants and myself if I am not paying for services in full.
 - I hereby authorize Dr. Sloan and his office to discuss unpaid bills with family members who are also patients (spouse, parents, etc.).
 - I further understand that I am responsible for payment of any amount not covered by my insurance and that I am responsible for payment should insurance not pay for services within 45 days from the date of service.
- Printed Name: _____ Date: _____ Signature: _____

Emergency Contact Information

Please provide the name of a friend or relative not living with you that we may contact if we cannot reach you at the above phone numbers.

Name: _____ Phone #: _____ Relationship to you: _____

If we are unable to reach you, may we leave a message on your machine? Yes No

Primary Pharmacy: _____ Phone #: _____ Fax#: _____