PATIENT INFORMATION

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

Address:_____City:_____State:_____Zip:_____

Home Phone #:_____**Work Phone #:**_____**Cell Phone #**_____

Email Address:_____Social Security #:_____

Married: Yes No Name of Spouse:_____

Name of Children who are patients at our office:_____

We are happy to file a courtesy, non-assigned (insurance pays patient) claim to your insurance company (all insurances except Medicare-as the doctor opted-out of Medicare) if you would provide the following information and let us copy your insurance card and driver's license.. At each visit just let us know if you want us to sent a claim to your insurance company.

Insurance Company:_____Phone #:_____

Mailing Address for CLAIMS:_____

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/parent/other**? Name to release information to: _____Relationship to you: Spouse Parent 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 available in the office and I have access to the Notice of Privacy Practices, HIPPA/HITECH rules and understand they are also posted on the website at www.tomsloanmd.com.**
- 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 so that I may be reimbursed by the insurance company.
- 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 at the time 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

Pharmacy Name:_____ **Location:**_____ **Phone #:**_____**Fax:**_____

NAME _____DATE OF BIRTH _____REFERRED BY _____

Have you ever had	NO	YES
Neurological Problems		
Major Eye Problems		
Major Ear Problems		
Psychological Problems		
Thyroid Problems		
Diabetes		
Heart Trouble		
High Blood Pressure		
High Cholesterol		
Lung Problems		
Liver, Gallbadder or Pancreas Problems		
Esophagus, Stomach, or Intestinal Problems		
Rectal Problems		
Prostate Problems (Men)		
Bladder Problems		
Kidney Problems		
Breast Problems		
Childbirth		
Male or Female Organ Problems		
Major Infections		
Arthritis		
Major Back Problems		
Major Skin Problems		
Anemia		
Blood Transfusion		
Cancer		
Other Problems		
Surgery		
Hospitalization		

Are you allergic to any medicine?
Place of Birth:
Occupation:
Religion:
Marital Status:
Have you ever smoked?

_____ _____ _____

Have any of the following--
Father, Mother, Brothers, Sisters, or Children ever had:

	NO	YES
Cancer		
Heart Trouble		
High Blood Pressure		
Diabetes		
Stroke		
Problems that run in the family		
Other Problems		

Please list any of the following who are deceased:
Father, Mother, Brothers, Sisters, or Children.

RELATIONSHIP	AGE AT DEATH	CAUSE OF DEATH