PATIENT INFORMATION

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

Address:_____City:_____State:_____Zip:_____

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

Email: _____

Married: Yes No Name of Spouse:_____

We are happy to file a courtesy (non-assigned) claim to your insurance company and insurance would send all correspondence and/or payment to you – just let us copy the front and back of your insurance card and your driver's license. (*Exception: we are unable to file to Medicare as the doctor "opted out" of Medicare.*) Otherwise, we will provide you with a receipt so you can file.
Always let us know when you checkout at each visit if you would like your claim filed.

Insurance Company: _____Policy #:_____ Group#:_____

Mailing Address for claims:_____

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 posted in the office and I have received the Notice of Privacy Practices and have been provided an opportunity to review it. They are also on the website: 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. (continuation of care)
- I hereby authorize Dr. Sloan and his office to furnish medical information to insurance carriers concerning my illness, treatment, and tests *if and only if I request non-assigned claims to be sent* from the office.
- I hereby authorize Dr. Sloan and his office to discuss unpaid bills with family members who are also patients (spouse, parents, etc.).
- For patients 65 and older, I understand that the doctor has "opted out of Medicare" and that a private contract must be signed stating Medicare will make no payments regarding anything done in this office and no claim can be submitted to Medicare.
- I further understand that I am responsible for payment at the time services are provided.

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

"My usual" Pharmacy:_____**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

MEDICAL HISTORY