# PATIENT INFORMATION SHEET

FULL NAME _____ DATE_____
ADDRESS_____
STREET CITY STATE ZIP CODE
HOME PHONE_____ CELL PHONE/ PAGER_____
DATE OF BIRTH:_____ AGE: _____
SEX_____ MARITAL STATUS_____ SOCIAL SECURITY #_____

EMPLOYMENT_____ WORK PHONE_____
PRIMARY CARE DOCTOR_____
Name Address

(If under 18 year old)
GUARDIAN/PARENT_____RELATIONSHIP_____HOME PHONE_____
(Mother, Father, Guardian)
ADDRESS_____
STREET CITY STATE
ZIP CODE
EMPLOYMENT_____WORK PHONE_____
SOCIAL SECURITY #_____ BIRTH DATE_____

EMERGENCY INFORMATION (SOMEONE NOT LIVING WITH YOU)
NAME_____RELATIONSHIP_____HOME PHONE_____
ADDRESS_____
STREET CITY STATE ZIP CODE

INSURANCE INFORMATION (PLEASE PRESENT CARDS)
COMPANY NAME_____ SUBSCRIBERS NAME_____
POLICY #_____GROUP #_____ EFFECTIVE DATE_____
SECONDARY INSURANCE_____

I patient and I guarantor, acknowledge and understand that I am responsible for any of the charges for services rendered to the above-named patient. I further acknowledge that all of the above information is true and accurate.

I authorize the release of any medical records to those physicians who have in the past or will be participating in the above-named patient's care. I authorize the release of any medical information necessary to process any and all insurance claims. I also authorize payment of medical benefits directly to Dr. Tolis Simon or Bluegrass Allergy and Asthma.

**I understand that if my insurance requires me to see a participating provider and obtain a referral, it is my responsibility to do so.**

SIGNED_____, PATIENT DATE_____
SIGNED_____, GUARANTOR DATE_____

IT IS IMPORTANT THAT YOU KNOW THE EXTENT OF YOUR INSURANCE COVERAGE