

PATIENT INFORMATION

Please print. All information is confidential.



Date _____

Name _____

Date of Birth _____ Age _____ SS# _____

Male Female Single Married Divorced Widowed Separated

Address _____

Home Phone # _____ Cell Phone# _____ Work Phone# _____

Email _____

Employer _____ Occupation _____

Business Address _____

Spouse's Name _____

Person to contact in case of emergency _____

Emergency Contact Telephone # _____

Whom may we thank for referring you? _____

If a college student or under 18 please provide:

Parent/ Guardian's Name _____

Address _____

Home Phone# _____ Work Phone # _____

Insurance Information:

Name of insured _____ Date of birth _____

SS# _____ Relationship to patient _____

Insurance Company _____

Address to send claim _____

ID/Policy# _____ Group# _____

Name of Employer _____

Address of Employer _____

Secondary Insurance:

Name of insured _____ Birth date _____

Insurance Company _____

Address to send claim _____

ID/Policy# _____ Group# _____

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to Samuels Care Center.

Signature of patient or parent/guardian if minor

Date