SPRING CITY
Health Centre

817 N East Avenue Waukesha, WI 53186
262-547-3055

PATIENT INFORMATION SHEET

PATIENT NAME _____ SSN# XXX-XX-_____

ADDRESS_____

CITY/STATE/ZIP_____ HOME PHONE#_____

DATE OF BIRTH_____ [ ] MALE [ ] FEMALE CELL PHONE#_____

MARITAL STATUS: [ ] SINGLE [ ] MARRIED [ ] DIVORCED [ ] WIDOWED [ ] SEPARATED [ ] _____

PATIENT'S EMPLOYER_____ OCCUPATION_____

EMPLOYER'S ADDRESS_____

CITY/STATE/ZIP_____ WORK PHONE#_____

RESPONSIBLE PARTY_____ DATE OF BIRTH_____

ADDRESS_____ SSN# XXX-XX_____

CITY/STATE/ZIP_____ RELATIONSHIP_____

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CASH PAYING _____

PRIMARY INSURANCE_____ INS PHONE #_____

SUBSCRIBER NAME_____ DATE OF BIRTH_____ RELATIONSHIP_____

SUBSCRIBER SSN# XXX-XX_____ ID/GROUP#_____

EMPLOYER NAME/ADDRESS _____

_____

SECONDARY INSURANCE_____ INS PHONE #_____

SUBSCRIBER NAME_____ DATE OF BIRTH_____ RELATIONSHIP_____

SUBSCRIBER SSN# XXX-XX-_____ ID/GROUP#_____

EMPLOYER NAME/ADDRESS _____

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EMERGENCY CONTACT_____ RELATIONSHIP_____

PHONE#_____ ADDRESS_____

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____AUTHORIZE MESSAGE ON ANSWERING MACHINE/VOICE MAIL

____ AUTHORIZE MEDICAL INFORMATION TO BE LEFT WITH _____.

GENERAL CONSENT

I HEREBY AUTHORIZE DIRECT PAYMENT TO PHYSICIAN FOR SERVICES PROVIDED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY **DEDUCTIBLE, COPAYMENTS, AND NON-COVERED SERVICES AT THE TIME OF SERVICE**. IN ADDITION, I HEREBY AUTHORIZE THE PHYSICIAN TO RELEASE ANY INFORMATION REQUIRED TO PROCESS CLAIMS TO MY INSURANCE CARRIERS LISTED ABOVE.

SIGNATURE_____ DATE_____