Marias Healthcare Services Inc

PATIENT INFORMATION

Patient Information

Name:_____ Birthdate:_____ Age:_____ Sex: M F

Mailing Address:_____ City_____ State_____ Zip_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

OK to leave message at: Home? Y__ N__ Work? Y__ N__ Cell? Y__ N__

Email: _____ Employer:_____

Marital Status: M S W D Sep Social Security #:_____

Race: Asian African American Native American White More than 1 race

Ethnicity: Hispanic Non-Hispanic Language Preferred: English_____ Other _____

Are you a veteran of the armed forces? Yes No Pharmacy Name:_____

Spouse or Parent Information

Name:_____ Birthdate:_____ Age:_____ Sex: M F

Social Security #: _____ Work Phone:_____

Insurance Information *(We will need to make a copy of your insurance cards.)*

Primary Medical Insurance Company _____

Secondary Medical Insurance Company _____

Dental Insurance Company _____

Billing Information

Person Responsible for bill _____ Relationship_____

Billing Address:_____ City_____ State_____ Zip_____

Phone #_____ Work Phone_____

EMERGENCY INFORMATION

Name of relative or friend not living with you that we can contact in case of an emergency:

Name:_____ Relationship_____ Phone_____

TREATMENT, ASSIGNMENT & RELEASE: I hereby request and authorize Marias Healthcare and its providers to treat me for health problems or conditions identified in the course of assessment and evaluation. I also hereby authorize direct payment of benefits to be paid directly to the provider. I understand and agree to pay any and all charges that exceed or that are not covered by insurance. I authorize the provider or insurance company to release any medical, dental or incidental information that may be necessary for either medical or dental care or in processing applications for payment benefits for services rendered.

Signed:_____ Date:_____