PATIENT INFORMATION SHEET
(Please fill out all information)

Date: _____
Chart# _____

Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____
Address: _____ Home Phone: _____
City: _____ State: _____ Zip: _____ Cell Phone: _____
Birthdate: _____ Email: _____ Beeper/Cellular: _____
Sex: Male or female (circle one) **Social Security #**: _____
Marital Status: Married / Single / Divorced / Separated / Widowed **Driver's License #** _____
(Circle One)

Employment Information

Employer Name: _____ Occupation: _____
Employer Address: _____ City: _____ State: ___ Zip ____

Responsible Party

Responsible Party: _____ **Birthdate**: _____
Address: _____ Home Phone: _____
City: _____ State: _____ Zip: _____ Cell Phone: _____
Employer: _____ **Social Security #**: _____
Employer Address: _____ **Driver's License#**: _____
City: _____ State: _____ Zip: _____

Insurance Information

Primary Insurance: _____ Subscriber's Name: _____
Your relationship to subscriber: Self / Spouse / Child / Other: _____
Identification# _____ Group# _____ Subscriber DOB: _____
(Circle one)
Secondary Insurance: _____ Subscriber's Name: _____
Identification #: _____ Group# _____ Subscriber DOB: _____

PLEASE GIVE RECEPTIONIST YOUR INSURANCE CARD AND DRIVER'S LICENSE TO PHOTOCOPY

Emergency Contact & Family Member Information

Emergency Contact: _____ Relationship: _____ Home Phone: _____
Address: _____ City: _____ State: _____ Zip: _____ Work Phone: _____
Please list immediate family members:

LAST NAME	FIRST NAME	M.I.	AGE	BIRTHDATE	RELATIONSHIP	SEX

We utilize Med Assist, P.A., minor emergency center, to provide after hours and overflow coverage for our office. As required by state law Dr. Tague is informing you that he is a partner in the ownership of Med Assist. You have the option of choosing another minor emergency center or an emergency room of your choosing at any time.

Thank you for selecting Dr. Tague for your health care needs. We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. **Please be advised that co-payment for all services will be due at the time services are rendered**. For your convenience, we accept Cash, Visa, MasterCard, Discover, and checks.

I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, accrued interest, attorney's fees, and court costs.

I authorize the exchange of my medical record and/or information concerning my condition to consultant physicians or other health care providers as determined by Dr. Tague to be in the best interest of my further treatment.

I have read and understand all of the above and have agreed to these statements._____
10/4/17 PATIENT OR RESPONSIBLE PARTY SIGNATURE