PATIENT INFORMATION FORM

PATIENT NAME:_____ **DOB:**_____

STREET:_____ **APT:**_____

CITY:_____ **STATE:**_____ **ZIP:**_____

SEX: M____ F____ **MARITAL STATUS:**_____ **S.S#**_____

E-MAIL ADDRESS:_____

HOME PHONE#:_____ **CELL#:**_____

OCCUPATION:_____ **WORK#:**_____

EMPLOYER:_____

RACE:
- ___AMERICAN INDIAN OR ALASKA NATIVE
- ___ASIAN
- ___AFRICAN AMERICAN
- ___NATIVE HAWAIIAN OR PACIFIC ISLANDER
- ___WHITE
- ___DECLINE TO ANSWER

ETHNICITY:
- ___HISPANIC
- ___NON-HISPANIC
- ___ DECLINE TO ANSWER

LANGUAGE:_____

EMERGENCY CONTACT NAME:_____
EMERGENCY CONTACT PHONE#:_____

PRIMARY CARE PHYSICIAN:_____ **PHONE#:**_____

SPEACIALIST NAME & PHONE#
1. _____
2. _____
3. _____
4. _____

PHARMACY NAME:_____ **PHONE#:**_____

PRIMARY INSURANCE NAME:_____ **ID#:**_____ **GROUP#:**_____
SECONDARY INSURANCE NAME:_____ **ID#:**_____ **GROUP#:**_____

CONSENT: I request and authorize Health Care Services by my physician and his/her designees as may deem advisable. This may include routine diagnostic, radiology and laboratory procedures and medication administration. A chaperone will be available for any exam by request, and may be refused at my discretion. YES____ NO____

MEDICAL BENEFITS PAYMENT AUTHORIZATION: I authorize payment of medical benefits to Dr. Christopher Kowalski for the amount due on any pending claim for services rendered. YES____ NO____

SIGNATURE:_____ DATE:_____