CONSULTANTS IN INTERNAL MEDICINE, P.C.

Patient Information

PATIENT DATA							
PATIENT LAST NAME	FIRST	MI	SEX	MARITAL STATUS	BIRTHDATE	AGE	Email address:
CURRENT MAILING ADDRESS				CITY	STATE	ZIP	PHONE
PERMANENT ADDRESS				CITY	STATE	ZIP	CELL PHONE
PATIENT'S EMPLOYER				OCCUPATION		SOCIAL SECURITY #	
EMPLOYER ADDRESS				CITY	STATE	ZIP	EMPLOYER PHONE

POLICY HOLDER INFORMATION				
POLICY HOLDER	SOCIAL SECURITY #		BIRTHDATE	
ADDRESS	CITY	STATE	ZIP	PHONE
EMPLOYER NAME	OCCUPATION			
EMPLOYER ADDRESS	CITY	STATE	ZIP	EMPLOYER PHONE

IN CASE OF EMERGENCY NOTIFY			
#1	RELATIONSHIP	PHONE	PHONE
#2	RELATIONSHIP	PHONE	PHONE

INSURANCE INFORMATION						
PRIMARY INS. CO.		GROUP NAME OR #	IDENTIFICATION #			COPAY
INS. CO. ADDRESS		CITY	STATE		ZIP	PHONE
POLICY HOLDERS NAME	POLICY HOLDERS SS#	EFFECTIVE DATE OF INS.	COVERAGE 100%____ 90%____ 80%____			OTHER ____
SECONDARY INS. CO.		GROUP NAME OR #	IDENTIFICATION #			DEDUCTIBLE
INS. CO. ADDRESS		CITY	STATE		ZIP	PHONE
POLICY HOLDERS NAME		EFFECTIVE DATE OF INS.	COVERAGE 100%____ 90%____ 80%____			OTHER ____

The above information is true and accurate as of this date

____ DATE __________

AUTHORIZATION TO TREAT MINOR

I accept responsibility as the patient's legal/financial representative for permission to treat.

PARENT OR LEGAL GUARDIAN SIGNATURE ______________________________ DATE __________