Consultants In Internal Medicine

New Patient Information Sheet

Patient Information

Name (Last, First, MI)_____

Home #:_____Cell #:_____Social Security #:_____

Birthdate:_____Gender:_____Marital Status:_____

Mailing Address:_____City:_____State:_____Zip:_____

Permanent Address:_____City:_____State:_____Zip:_____

Employer:_____Occupation:_____

Employer Address:_____Employer phone #:_____

Patient's email address:_____

Emergency Contact

#1:_____Relationship:_____Phone #:_____

#2:_____Relationship:_____Phone #:_____

Pharmacy Information

Pharmacy Name:_____Pharmacy Phone #:_____

Pharmacy Location (City, Crossroads):_____

Insurance Information

Insurance Company:_____Insurance ID #:_____

Policy Holder:_____Birthdate:_____Social Security #:_____

The above information is true and accurate as of this date.

Signature:_____Date:_____

Authorized to treat a minor

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

Parental/Legal Guardian:_____Date:_____