PATIENT INFORMATION SHEET

NAME (LAST) _____ (FIRST) _____ (INITIAL) _____
(As listed on your insurance)

PHONE (HOME) _____ (WORK) _____

ADDRESS:
STREET: _____
CITY: _____
STATE: _____ ZIP: _____

MAILING ADDRESS: (IF DIFFERENT)
P.O. BOX/STREET _____
CITY: _____
STATE: _____ ZIP: _____

Patient's Date of Birth: _____

Patient's Social Security #: _____

Patient's Occupation: _____

Patient's Legal Status (circle one) □ Single □ Married □ Separated □ Divorced □ Widow
Subscriber's Soc. Sec # _____
Emergency Contact: _____ Phone: _____

Nearest of Kin: _____ Phone: _____
(if under 18 years of age, parent, guardian, etc.)

Person To Receive Bill: _____ Phone: _____

Address: _____
(if different from above:)

Primary Care Physician: _____

HEALTH INSURANCE:

Blue Shield: Cert # _____ Subscriber Name: _____

State: _____ Group # _____
(If on insurance card)

Name of Your Insurance:
Insurance Address: _____
(If on back of card)

Medicare #: _____
Medex #: _____

Subscriber: _____
Patient's ID # _____
(On insurance card)

Group # _____
(If on insurance card)

No Insurance (Circle if applicable)

I hereby authorize my insurance benefits to be paid directly to Assurance Counseling, LLC. For medical services rendered. I also authorize Assurance Counseling, LLC. to release any information necessary to process this claim

Signature: _____ Date: _____