HILL FAMILY MEDICINE & SKIN CARE

PATIENT INFORMATION SHEET

Patient Information:

Name:____
(Last) (First) (Middle)

Address:_______________________________ City:_________________ State:__________ Zip:___________

Home Phone:___________________ Cell Phone:____________________ Drivers License:_________________

Birth Date:_____________________ SSN:__________________ Sex: ☐ Male ☐ Female Age:___________

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Widowed

Race: ☐ American Indian / Alaska Native ☐ Asian ☐ Black / African American ☐ Pacific Islander
☐ White ☐ Other ☐ Unknown ☐ Decline

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline

Employer:____________________________________ Work Phone:___________________________________

Name of **Spouse** or **Parent** (Circle One):____________________ DOB:_________ SSN:_________________

Employer of Spouse/Parent:_____________________________ Work Phone:__________________________

E-mail: ____________________________________ ****Preferred contact method: ☐ Phone ☐ Text ☐ Email**

Emergency Contact Information:

Emergency Contact (Not Living in Same Household):____

Phone:________________ Alt. Phone:___________________ Relation to Patient:______________________

Insurance Information:

Date of Injury/Illness:__________________________ Work Related: ☐ No ☐ Yes

Primary Insurance Co:____ Phone:_______________________

Claims Address:________________________ City:_________________ State:__________ Zip:___________

Name of Policyholder:___________________________ ID:___________________________ Group:________________

DOB of Policyholder:_____________________ SSN:_________________ Relation to Patient:______________

Policyholder's Employer:_______________________________________ Phone:_______________________

Secondary Insurance Co:_____________________________________ Phone:_______________________

Claims Address:________________________ City:_________________ State:__________ Zip:___________

Name of Policyholder:___________________________ ID:___________________________ Group:________________

DOB of Policyholder:_____________________ SSN:_________________ Relation to Patient:______________

Policyholder's Employer:_______________________________________ Phone:_______________________

How were you referred to Hill Family Medicine & Skin Care?

****Referring Physician:**______________________________ **City:**________________ **Phone:**________________

☐Insurance Company ☐ Website ☐ E.R. if so which ER:________________ ☐ Friend/Family ☐ Prior Patient ☐ Other

Authorization:

Financial Responsibility, Assignment of Benefits, Authorization to Release Information:

I hereby authorize the physician to release information in connection with my treatment to my insurance company, employer, their representative, or referring physician at such time as information is requested. I authorize assignment of benefits to my physician.

Consent For Treatment:
I do hereby consent to necessary examination procedures and/or treatment by my physician, his/her assistants, designees as is necessary in his/her judgment.

______________________________________ ______________________________________
Patient's Signature Date Guardian's Signature Date