

ST. LUKE'S MEDICAL CLINIC
Patient Information Sheet

PLEASE PRINT NEATLY AND CLEARLY:

DATE: _____

PATIENT NAME: _____ DATE OF BIRTH: _____

HOME ADDRESS: _____

(city) (state) (zip code)

PHONE (C H W): _____ ALT (C H W): _____ ALT (C H W): _____

SS#: _____ GENDER: M F EMAIL ADDRESS: _____

PHARMACY NAME/PHONE: _____ MARITAL STATUS: M S W D

EMPLOYER: _____ PHONE#: _____

EMPLOYER ADDRESS: _____

NEXT OF KIN: _____ RELATION: _____ PHONE #: _____

EMERGENCY CONTACT: _____ PHONE #: _____

INSURANCE INFORMATION:

PRIMARY INSURANCE

INS. CO. NAME: _____ PHONE #: _____

INSURED'S NAME: _____ INSURED'S EMPLOYER: _____

POLICY #: _____ GROUP #: _____

SECONDARY INSURANCE

INS. CO. NAME: _____ PHONE #: _____

INSURED'S NAME: _____ INSURED'S EMPLOYER: _____

POLICY #: _____ GROUP #: _____

I, _____, do hereby assign all medical benefits of which I am entitled, including Medicare, Private Insurance, and other health plans to:

ST. LUKE'S MEDICAL CLINIC

I understand that I am financially responsible for any balance not covered by my insurance. I hereby authorize St. Luke's Medical Clinic to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit. This assignment will remain in effect until removed by me in writing. A photocopy of this assignment is to be considered as valid as an original.

PATIENT SIGNATURE: _____ DATE: _____

PARENT/GUARDIAN: _____ DATE: _____