PATIENT INFORMATION FORM

DATE____________ PATIENT NAME________________________________ Birthdate__________ M or F

SOCIAL SECURITY#______________________________ MARITAL STATUS: S M D W Sep (Circle)

ADDRESS____ ZIP CODE__________
Street City State

Primary contact phone #1____________________ 2nd # ___________________________
(circle one) Cell Home Work (circle one) Cell Home Work

OCCUPATION___________________________ EMPLOYER_____________________________________

SPOUSE OR RESPONSIBLE PARTY NAME_________________________________ Birthdate__________

Social Security #_________________________________

MEDICAL INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY____

ID#_________________________________ COPAY/DEDUCTIBLE Y N AMOUNT $_____________

INSURED'S NAME______________________________ DOB________ SOC SEC#_________________

GROUP NAME AND/OR #______________________________

SECONDARY INSURANCE COMPANY ____

ID#_________________________________ COPAY/DEDUCTIBLE Y N AMOUNT $_____________

INSURED'S NAME______________________________ DOB_________ SOC SEC#_________________

GROUP NAME AND/OR #______________________

(PLEASE USE REVERSE IF THERE IS A TERTIARY INSURANCE)

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with____, and assign directly to Shoreline Medical Associates, LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Shoreline Medical Associates to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

________________________________ ___________________________ ___________________________
Responsible party signature Relationship Date

LIVING WILL Yes___ NO___

Person to be notified in case of emergency_________________________ Phone________________