**GREATER SANDHILLS FAMILY HEALTHCARE, P.C.**

**Patient Information Sheet**

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| --- | --- | --- | --- |
| Patient Name: | M Initial: | DOB: | SSN: |
| Patient Address: City: State: Zip: |
| Home Phone: | Work Phone: | Cell Phone: |
| Employment: | Marital Status: S/ M/ W | Sex: M / F |
| Father (if patient is a minor) / Spouse Name: | SSN: | DOB: |
| Mother Name: | SSN: | DOB: |
| Send Billing Statements To: Name | AddressCity: State: Zip: |
| Employer Name: | Phone: |
| **Notify In Case of Emergency** |
| 1. Name:
 | Relationship: |
| Home Phone: | Work Phone: | Cell phone: |
| 1. Name:
 | Relationship: |
| Home Phone: | Work Phone: | Cell phone: |
| **Primary Insurance Company Name:** |
| Group Name: | Group Number: | Address: |
| Policy #: | Effective Date: | Expiration Date: |
| Subscriber Name: | Co-Pay: |
| **Secondary Insurance Company Name:** |
| Group Name: | Group Number: | Address: |
| Policy #: | Effective Date: | Expiration Date: |
| Subscriber Name: | Co-Pay: |

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. It is customary to pay for services when rendered unless other arrangements have been made in advance with our office bookkeeper. **INSURANCE AUTHORIZATION AND ASSIGNMENT:** I hereby authorize Greater Sandhills Family Healthcare Clinic to furnish information to insurance carriers concerning my illness and treatments, and I herby assign to the physician all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

**CONSENT:** I, (or \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) do herby voluntarily consent to such diagnostic procedures, hospital care, and medical and surgical treatment by Greater Sandhills Family Healthcare Clinic physician (s), physical assistant, nurse practitioner, or physician designees as is necessary in his/her judgment. I acknowledge that no guarantees have been made to me as the result of treatments or examination in this facility.

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Revised 12.18.21)