Skurcenski
PRIMARY CARE

PATIENT INFORMATION FORM

Date: _____

Patient Name_____ Date of Birth_____ Age_____

Social Security # _____

Address_____

Telephone_____ Cell_____ Email _____

Other family members living at this address: _____

Marital Status: Single__Married___Spouse's Name_____Divorced ___Widowed___Separated____

Employer: _____Work Number: _____ Ext: _____ Other: _____

Emergency Contact: _____ Relationship: _____

Contact Telephone #s: Home: _____ Cell: _____ Work: _____ Ext: ____

May we leave a message regarding your medical care at your home? Yes/No

On your cell phone voice mail? Yes/No On your work voice mail? Yes/No

If patient is a minor (under 18 years of age), please complete the following:

Mother's Name: _____ _____ _____

Telephone #'s: Home: _____ Cell: _____ Work: _____ Ext:_____
Email: _____

Father's Name: _____ _____ _____

Telephone #'s: Home_____ Cell_____ Work_____ Ext:_____
Email:_____
Who has legal custody of the patient? Both Parents____ Mother ____ Father _____Guardian_____
If guardian complete the following: Name _____

Address: _____ (city, state, zip)

Telephone #'s: Home: _____ Cell: _____ Work: _____ Ext: ____

Referred by: _____ Former Doctor_____
Have you had information from another Dr./Facility forwarded to this office? Yes____ No____
If yes, who from? _____
Reason for transferring your care: Relocation_____ Insurance_____Accessibility_____Other_____
Do you have insurance? Yes____ No_____

If yes, please complete the following insurance/billing information.

Primary Insurance:_____ ID#:_____
Group#:_____ Insurance Company Name: _____
Subscriber: _____ Relationship to Subscriber: _____
Subscriber's Date of Birth:_____ Subscriber's SS#: _____

Secondary Insurance: _____ ID#: _____ Group#: _____
Insurance Company Name: _____ Subscriber:_____
Relationship to Subscriber:_____ Subscriber's Date of Birth: _____
Subscriber's SS#: _____

Guarantor: (Person responsible for co-payments and for charges which are NOT covered by insurance)
Guarantor's Name: _____ Guarantor's SS#: _____

Address (required for accurate billing): _____

AUTHORIZATION:

I hereby authorize Skurcenski Primary Care to furnish information to any insurance carriers concerning my medical care, and I hereby irrevocably assign Skurcenski Primary Care any payment for services rendered.

I understand that I am responsible for all charges whether or not covered by insurance.
I certify that this information is accurate as of this date.

SIGNATURE: _____ Date : _____