Onslow Surgical Clinic

Patient Information Sheet

Patient Name:	**Acct #:**	**Date of Birth:**	
Marital Status:	Sex:	Age:	
Address:	City:	St:	Zip:
Soc. Sec.#:	Home Ph:	Cell Ph.:	
Employer:		Work Ph.:	
Emp. Address:	City:	St:	Zip::
Email Address:	Primary Language:		
How did you hear about our practice?			

RACE: (*If undefined please check box)*)

☐ AMERICAN INDIAN / ALASKA NATIVE ☐ ASIAN ☐ BLACK/AFRICAN AMERICAN ☐ NATIVE HAWAIIAN
☐ OTHER PACIFIC ISLANDER ☐ WHITE ☐ MORE THAN ONE RACE ☐ REFUSED TO REPORT

ETHNICITY: (*If undefined please check box)*)

☐ HISPANIC / LATIN AMERICAN ☐ NON-HISPANIC / LATIN AMERICAN ☐ REFUSED TO REPORT

Responsible Party:	Sex:	Date of Birth:	
Address:	City:	St:	Zip:
Soc. Sec.#:	Home Ph.:	Cell Ph.:	
Employer:		Work Ph.:	
Referring Doctor:	**Family Physician:**		
Emergency Contact (Outside the household) :			
Home Ph.:	Cell Ph.:	Relationship:	

HEATLH INSURANCE INFORMATION

PRIMARY INSURANCE	SECONDARY INSURANCE
Carrier Name:	Carrier Name:
Subscriber Name:	Subscriber Name:
Date of Birth:	Date of Birth:
Policy ID:	Policy ID:
Group #:	Group #:
Specialist Co-Pay:	Specialist Co-Pay:

ACCIDENT INFORMATION

Date of Injury:	Time of Injury:
WORKERS COMPENSATION INFORMATION	MOTOR VEHICLE INSURANCE INFORMATION
Carrier Name:	Carrier Name:
Address:	Address:
City, St Zip:	City, State Zip: «PL1VCity»
Claim # :	Claim #: «PL1VCert»
Adjustor:	Adjustor:
Telephone:	Telephone:

All professional services rendered are charged to the patient. Our office, to help assure insurance payments, will complete necessary forms. The patient is responsible, however for the fees, regardless of insurance coverage. If you will provide insurance information, we will file your insurance. If you do not wish for us to file you insurance, please initial here. _____

I hereby authorize physician of Onslow Surgical Clinic to furnish information to insurance companies concerning my illnesses and treatments and I hereby assign to the provider all payments for medical services tendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. I certify that the above information is correct. A photocopy of this authorization shall be considered as valid as the original.

I have read the above information.

_____
Signature of Patient or Responsible Party

_____
Date