Patient Information Sheet

HEAD OF HOUSEHOLD INFORMATION

Head of Household: David Chin

Occupation: Biologist

Social Security #: 222-33-444

Sex: M

Date of Birth: 04/04/1990

Address: 4536 Deliverance Road

Home phone #: 541-333-4444

City, St.: Albany, Oregon

Zip: 97321

Employer's Name: Oregon State Department of Fish and Wildlife

Employer's Address: 66 State Street

Employer's phone #: 541-444-1234

Employer's City, St. Salem, Oregon

Employer's Zip: 97255

PATIENT INFORMATION

Patient's Legal Name: Amanda Chin

Nickname:

Sex: F

Date of Birth: 05/05/1990

Marital Status: Married

Relationship to head of household: Spouse

Social Security #: 111-33-7777

Employer Name: ABC123 House

Employer phone #: 541-333-3456

Employer Address: 89 Blue Street

Employer's City, St.: Albany

Zip: 97321

Referring Physician: Seymour Koffs

Allergies:

EMERGENCY INFORMATION

Other contact not living with you: Todd Chin

Home Phone #: 541-333-4444 Work phone #: None

Address 123 Eclipse Drive

City, St. Albany, Oregon Zip: 97321

Patient relationship to other contact: Father in Law If patient is a child, parent name:

INSURANCE INFORMATION

Primary Insurance: BCBS Subscriber: David Chin

ID#: ABC810167777 Relationship to subscriber: Spouse

Secondary Insurance: None Subscriber:

ID#: Relationship to subscriber:

OTHER FAMILY MEMBERS:

Name: Date of Birth:

Name: Date of Birth:

Name: Date of Birth

Name: Date of Birth:

I understand that it is my responsibility that any incurred charges are paid.

To the extent necessary to determine liability for payment to obtain reimbursement, process claim forms, I authorize the release of any medical information necessary to process claims.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and other health plans to Acumen Medical Practice, Somewhere, OR 12345

This assignment will remain in effect until revoked by me in writing, a photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure the payment.

Signature: SOF Date: 11/30/2014