Patient Data Information

Name ______________________________ Birth Date ____ / ____ / ____ Sex: ☐ Male ☐ Female

Phone____________________ Cellular Phone ________________ Email ______________________________

Ok to leave a message? ☐ Yes ☐ No

Address______________________________________ City ________________ State _____ Zip _________

SS# ________________________ Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Race: ____________________ Ethnicity: ___________________ Referred by ____________________________

Pharmacy (name, location, phone #) ____

Mail Order Pharmacy (if applicable)____

Emergency Contact: ______________________________ Relationship _____________ Phone ________________

Preferred Method of Communication (Choose One) : ☐ Phone ☐ Text

PATIENT INSTRUCTIONS FOR COMMUNICATION PREFERENCES:

I authorize Silver Cross Medical Group to contact for results:

Myself Only ☐

☐ Home

☐ Cell

Ok to leave a message on answering machine? ☐ Yes ☐ No

Other ☐ Name ____ Relationship _________________________

Other ☐ Name ____ Relationship _________________________

Did you sustain an injury at work? ☐ Yes ☐ No Are your injuries accident related? ☐ Yes ☐ No

Authorization to Treat:

I hereby authorize my insurance benefits to pay directly to Silver Cross Medical Group, realizing I am responsible to pay non-covered services. I authorize the release of medical information to insurance carrier.

Signature: ____ Date __________________