THE SLOAN CLINIC - PATIENT INFORMATION SHEET

☐ Male ☐ Female (☐ *Mrs.* ☐ *Miss* ☐ *Ms.*)

Referring Physician: _____

Patient Name: _____ Social Security: _____
First *Middle Initial* *Last*

Personal Data

Address: _____ _____, _____ _____
City *State* *ZIP*

Home Phone: (_____)_____ - _____ Age: _____ Date of Birth: _____ / _____ / _____

Cell Phone: _____ Spouse's Name: _____ Phone: (_____)_____ - _____

Employer: _____ Phone: (_____)_____ - _____

Address: _____ _____, _____ _____
City *State* *ZIP*

Employment

May we contact you at your place of employment ☐ **NO** ☐ **YES**
Is this a Workers' Compensation claim? ☐ **NO** ☐ **YES** *(please complete Workers' Compensation section below)*

Emergency Contact *(not living at your address)*: _____ Relationship to patient: _____

Emergency

Address: _____ Phone: (_____)_____ - _____

Please Complete This Section if the Patient is Younger than 18 Years of Age

Party Responsible for Billing: _____ Relationship to patient: _____

Address: _____ Home Phone: (_____)_____ - _____

_____ Work Phone: (_____)_____ - _____

Under 18

Mother's Name / Legal Gurardian: _____ Father's Name _____

Address: _____ Address: _____

_____ _____

Phone: (_____)_____ - _____ Phone: (_____)_____ - _____

Primary Insurance Coverage: _____

ID #: _____ Group #: _____ Name of Subscriber: _____

Sex: ☐ Male ☐ Female Birth Date: _____/_____/_____ Relationship to Patient: _____

Secondary Insurance Coverage: _____

Insurance

ID #: _____ Group #: _____ Name of Subscriber: _____

Sex: ☐ Male ☐ Female Birth Date: _____/_____/_____ Relationship to Patient: _____

Other Insurance Coverage / Worker's Compensation Information: _____

Claim Number: _____ Contact Person: _____

Name of Plan: _____ Address: _____

Phone: (_____)_____ - _____ ext._____ Name of Employer _____

If payment is based on determination that problem is work related, patient must sign below. If company denies payment, it is understood that patient agrees to pay for services rendered in full within 30 days of date of service.

Signature: _____ **Date:** _____

- I consent to treatment necessary for the cure of the above named patient.
- I authorize the release of all medical records to the referring and family physicians and to my insurance company if applicable.
- I allow fax transmittal of my medical records if necessary.
- I acknowledge full financial responsibility for services rendered by The Sloan Clinic.
- I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment.
- I agree to pay all reasonable attorney fees and collections costs in the event of default of payment of my charges.
- I further authorize and request that insurance payments be made directly to The Sloan Clinic should they elect to receive such payment.
- I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

Signature: _____ **Date:** _____