PATIENT INFORMATION ENTRUST MEDICAL GROUP

NAME: _____ _____ _____ _____
FIRST MID INITIAL LAST SEX AGE BIRTHDATE

ADDRESS: _____ _____
NO . STREET SOCIAL SECURITY NUMBER

_____ _____MARRIED ____SINGLE_____DIV/SEP_____WIDOWED
CITY STATE ZIP Marital Status

_____ ____ yes___no _____ _____ _____
HOME PHONE NUMBER ID BLOCK CELL PHONE NUMBER WORK NUMBER E MAIL ADDRESS

EMPLOYER: _____ OCCUPATION: _____

_____ _____
WORK ADDRESS CITY STATE

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PRIMARY CARE PHYSICIAN: _____ PHONE # _____
Which physician referred you to us? _____ Other: _____

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NAME OF FINANCIALLY RESPONSIBLE PERSON: _____
FIRST MIDDLE LAST

ADDRESS: _____ _____
NO. STREET RELATIONSHIP TO PATIENT

_____ _____ _____
CITY STATE ZIP SOCIAL SECURITY NUMBER BIRTHDATE

HOME PHONE: _____ CELL PHONE _____ WORK PHONE_____

EMPLOYER: _____ OCCUPATION:_____

SPOUSE: _____ DATE OF BIRTH: _____

SPOUSE EMPLOYER: _____ SPOUSE OCCUPATION: _____

EMERGENCY CONTACT: _____ _____
NAME & RELATIONSHIP PHONE NUMBER

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INSURANCE INFORMATION: YOUR **PRIMARY** INSURANCE INFORMATION:

INS COMPANY NAME: _____ NAME OF INSURED PERSON:_____

INSURED DATE OF BIRTH: _____ INSURED SOCIAL SECURITY: _____

SECONDARY INSURANCE COMPANY INFORMATION:

COMPANY NAME: _____ NAME OF INSURED PERSON:_____

INSURED DATE OF BIRTH: _____ INSURED SOCIAL SECURITY: _____

I, THE UNDERSIGNED, REALIZE THAT ALL MEDICAL AND SURGICAL CHARGES INCURRED ARE MY FINANCIAL RESPONSIBILITY AND PAYABLE BY ME. I UNDERSTAND THE OFFICE WILL DO ITS BEST TO BILL ANY INSURANCE THAT I MAY HAVE, BUT I AM STILL ULTIMATELY RESPONSIBLE FOR THE CHARGES. I HEREBY AUTHORIZE AND DIRECT MY INSURANCE CARRIER TO PAY DIRECTLY TO ENTRUST MEDICAL GROUP ANY BENEFITS DUE TO ME AND UNDER MY INSURANCE PLAN, INCLUDING DEDUCTIBLES AND CO-PAYMENTS. I AUTHORIZE RELEASE OF INFORMATION FROM MY MEDICAL RECORD REQUIRED FOR TREATMENT OR BILLING PURPOSES.

_____ _____
AUTHORIZED SIGNAURE DATE