

PATIENT INFORMATION

ENTRUST MEDICAL GROUP

NAME: _____
FIRST MID INITIAL LAST SEX AGE BIRTHDATE

ADDRESS: _____
NO. STREET SOCIAL SECURITY NUMBER

CITY STATE ZIP MARRIED SINGLE DIV/SEP WIDOWED
Marital Status

HOME PHONE NUMBER ID BLOCK yes no CELL PHONE NUMBER WORK NUMBER E MAIL ADDRESS

EMPLOYER: _____ OCCUPATION: _____

WORK ADDRESS CITY STATE

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

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

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 SIGNATURE

DATE