

PATIENT INFORMATION				
PATIENT'S LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH	PRIMARY CARE PHYSICIAN
MAIDEN NAME	NAME YOU GO BY		MARITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W	
STREET ADDRESS			APT. NO.	
CITY	STATE	ZIP	HOME PHONE	
SOCIAL SECURITY NUMBER	AGE	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	CELL PHONE	
EMPLOYER	OCCUPATION		WORK PHONE	
EMERGENCY CONTACT (NOT LIVING WITH YOU) / RELATION TO PATIENT			EMERGENCY CONTACT PHONE	
SPOUSE INFORMATION OR PARENT / RESPONSIBLE PARTY INFORMATION				
LAST NAME	FIRST NAME	M.I.	RELATIONSHIP TO PATIENT <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Legal guardian <input type="checkbox"/> Other _____	
STREET ADDRESS			APT. NO.	HOME PHONE
CITY	STATE	ZIP	CELL PHONE	
SOCIAL SECURITY NO.			DATE OF BIRTH	
RESPONSIBLE PARTY EMPLOYER	OCCUPATION		RESPONSIBLE PARTY WORK PHONE/EXT.	
SECOND PARENT INFORMATION				
LAST NAME	FIRST NAME	M.I.	RELATIONSHIP TO PATIENT <input type="checkbox"/> Parent <input type="checkbox"/> Legal guardian <input type="checkbox"/> Other _____	
STREET ADDRESS			APT. NO.	HOME PHONE
CITY	STATE	ZIP	CELL PHONE	
SOCIAL SECURITY NO.			DATE OF BIRTH	
RESPONSIBLE PARTY EMPLOYER	OCCUPATION		RESPONSIBLE PARTY WORK PHONE/EXT.	
INSURANCE INFORMATION				
PRIMARY	INSURANCE COMPANY		COPAY	EFFECTIVE DATE
ID (POLICY NO.)		GROUP NO.		
SUBSCRIBER		RELATIONSHIP TO SUBSCRIBER	SUBSCRIBER'S DATE OF BIRTH	
SUBSCRIBER'S EMPLOYER			SUBSCRIBER'S SOCIAL SECURITY NO.	
SECONDARY	INSURANCE COMPANY		COPAY	EFFECTIVE DATE
ID (POLICY NO.)		GROUP NO.		
SUBSCRIBER		RELATIONSHIP TO SUBSCRIBER	SUBSCRIBER'S DATE OF BIRTH	
SUBSCRIBER'S EMPLOYER			SUBSCRIBER'S SOCIAL SECURITY NO.	

Insurance Payment Authorization and Release: I hereby authorize my insurance benefits to be paid directly to the SSM Health Medical Group and acknowledge that I am financially responsible for any unpaid balance. I also authorize the release of any information requested by my insurance company.

Authorized signature _____ Date _____

PLEASE BRING THIS FORM ALONG WITH YOUR INSURANCE CARD(S) AND APPLICABLE COPAY(S) TO YOUR APPOINTMENT. THANK YOU!