Piedmont HealthCare

Patient Information Sheet

Account#: _____ DOB: _____ Medical Record#: _____

Patient Name: _____
(First) (Middle) (Last) Social Security Number

Patient Address: _____ Home Telephone #: _____

_____ Emergency Number #: _____

Sex (Circle one): **Male** **Female** **Marital Status** (Circle one): **Married** **Single** **Other**

Primary Care Physician: _____ Referring Physician: _____

Patient's Employer: _____ Employer's Phone Number: _____

Employers Address: _____

Responsible Party's Name: _____
(First) (Middle) (Last) Social Security Number

Responsible Party's Address: _____ Responsible Party's Phone #: _____

Patient Relationship to Responsible Party:

_____ (Circle One) **Self** **Spouse** **Child** **Other**

Responsible Party's Employer: _____ Employer's Phone#: _____

Employer's Address: _____

Primary Insurance: _____ Employer's Name: _____

Policy #: _____ Patient's Relationship to Insured: _____

Insured's Name: _____ Insured's DOB: _____

Address: _____ Insured's Sex: Male Female

Phone #: _____ Insured's SSN: _____

Secondary Insurance: _____ Employer's Name: _____

Policy #: _____ Patient's Relationship to Insured: _____

Insured's Name: _____ Insured's DOB: _____

Address: _____ Insured's Sex: Male Female

Phone #: _____ Insured's SSN: _____

I hereby authorize Piedmont HealthCare to release information concerning my medical or surgical treatment to any insurance carrier, including Medicare and Medicaid. I further authorize payment being made directly to Piedmont HealthCare for my insurance benefits including major medical insurance. I understand that I am financially responsible to Piedmont HealthCare for my charges and that the filing of insurance does not relieve me of this obligation. I further authorize any payment made by insurance companies that are incorrect to be refunded to the insurance company. I consent to x-ray examinations, laboratory procedures and other medical treatment as recommended by my physician as provided by authorized personnel of Piedmont HealthCare. I also understand that Piedmont HealthCare is not responsible for any of my personal or valuable items I bring with me.

Signature (seal) _____ Date: _____

Information Verified by: _____ Date: _____