Healthcare For Seniors
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PATIENT INFORMATION SHEET

LEGAL NAME: _____ _____ ____
Last **First** **MI**

DOB: _____ **Home Number#** _____ **Cell #**_____

Address: _____

City_____ **State** _____ **Zip Code**_____

EMAIL: _____

required for billing purposes

***Social Security#**_____* **Medicare#**_____

***Medicare Advantage Name**_____

***ID#:**_____

***Secondary Ins Name:** _____

***Secondary Insurance ID#**_____

Marital Status: Single □ Married □ Divorced □ Widow/Widower □

If married, name of Spouse: _____

Spouse's Social Security Number: _____ **DOB:** _____

Physician/Other Referral Name and Phone:_ _____

Continued on other side

Is patient in an assisted living facility, personal care home or nursing home? _____

If yes, what is the name of the facility? _____

Telephone Number _____

If other than patient, to whom should all correspondence be mailed?

Name: _____ Address: _____

City_____ State ____ Zip _____ Phone: _____

Relationship to patient: _____ Power of Attorney? Yes ☐ No ☐
(Please provide a copy of the power of atty. for the chart)

****The power of attorney will be contacted first for all matters. If there is no power of attorney we will contact the person named above for all matters. In the event the patient, primary contact named above or power of attorney cannot be reached, please provide the name of another person that we may contact in case of an emergency.***

EMERGENCY CONTACT

Name: _____ Relationship to patient: _____

Home phone_____ Work phone _____ Cell _____

Release for billing

By signing below you give us authority to release any medical information deemed necessary to the appropriate insurance company in order to bill for your medical services. You also agree to accept full responsibility for any balances or co-pays that are not covered by your primary and/or secondary insurance company.

Signature: _____
(Patient or Power of Attorney)

Printed Name of Patient: _____

DATE: _____

Revised 05/05/2020 MKH