University Medical Center

Updated as of 7/19/16
Supersedes all prior versions

PATIENT INFORMATION

Patient Name _____ Chart # _____

Mailing Address _____ _____ _____ _____
Street *City* *State* *Zip*

DOB _____/_____/_____ SEX: ☐ Male ☐ Female Social Security #: _____-_____-_____

☐ Home Phone _____ ☐ Cell Phone _____ ☐ Work Phone _____

(Please check which number would be preferred number for contact)

Employer _____

Marital Status: ☐ single ☐ married ☐ divorced ☐ widowed RACE: _____

Spouse's Name _____ DOB ____/____/____ Last 4 digits of SSN _____

Spouse's Place of Employment _____

EMERGENCY CONTACT: _____ PHONE: _____

INSURANCE & RESPONSIBLE PARTY INFORMATION
(This section *must* be filled out)

Primary _____
Group #: _____
Policy #: _____
Responsible Party's Name (if other than patient)
_____
☐ **Male** ☐ **Female**
DOB: ___/___/____ **Phone** _____
Social Security #: _____-_____-_____
Address _____
Street
_____ _____ _____
City *State* *Zip*

Secondary _____
Group #: _____
Policy #: _____
Responsible Party's Name (if other than patient)
_____
☐ **Male** ☐ **Female**
DOB: ___/___/____ **Phone** _____
Social Security #: _____-_____-_____
Address _____
Street
_____ _____ _____
City *State* *Zip*

I authorize and request my insurance company to pay directly to University Medical Center any health benefits resulting from care received in that facility. I understand that my insurance company may not cover all services rendered on behalf of me or my dependents and I agree to assume responsibility for any services, procedures, devices, or testing not covered. I consent to the release to my insurance company of any medical record (except psychiatric) necessary to resolve claims for services rendered. I understand that co-pays and any services not covered by an insurance company are DUE IN FULL AT THE TIME OF SERVICE. Patient/guarantor understands that any credit balance *on a date of service* may be applied to other outstanding balances *due on other dates of services* for their personal account and/or for accounts for which they are the guarantor.

***Signature** _____ ***DATE**_____

***Relation to Patient** _____

FOR OFFICE USE ONLY:

Suite _____ Doctor _____

New Patient _____ Update _____ OC _____ WC _____