

UNIVERSITY MEDICAL GROUP PATIENT INFORMATION RECORD

Int
Date

(Please Print)

Date: _____ Phone: _____

Patient Name: _____ Social Security #: _____
First Name MI Last Name

Mailing Address: _____ City: _____ State: _____ Zip: _____

Sex: M F Age: _____ Date of Birth: _____ Single Married Widowed Separated Divorced

Employed by: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Patient's Spouse Information or <input type="checkbox"/> Not married	Spouse's Name	Spouse's SSN
	Name of Employer	Work phone
	Employer street address	Occupation <input type="checkbox"/> Student?
	City, State	Zip code Spouse's date of birth

If Patient is a minor (under 18 or student under 21), please provide the following Parental/Guardian information:

Patient's Father/Guardian's name	Mother's name
Address, City, State, Zip (if different from patient)	Address, City, State, Zip (if different from patient)
Date of birth SSN	Date of birth SSN
Employer Name Phone	Employer Name Phone

Insurance Information

Insurance Company: _____ Policy Holder: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Group #: _____ Policy #: _____

Medicare #: _____ Medicaid #: _____

Emergency Contact

In the event of an emergency involving patient who should we contact?

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Minor/Child Consent: I, being the parent of _____, do hereby request and authorize the staff of Lee Family Clinic d.b.a. University Medical Group to perform necessary medical services for my child, including, but not limited to x-rays, and administration of anesthetics, etc., which are deemed advisable by the treating physicians of Lee Family Clinic d.b.a. University Medical Group, whether or not I am present at the actual appointment when the treatment is rendered.

Insurance Authorization: I, hereby authorize Lee Family Clinic d.b.a. University Medical Group to furnish information to my insurance carriers concerning illnesses or accidents for which claims for reimbursements are made on my behalf and hereby irrevocably assign to the attending physician all payments for medical services rendered by Lee Family Clinic d.b.a. University Medical Group's attending physician. I understand that I am financially responsible for all charges whether or not covered by insurance and that this authorization will be in effect until revoked by me.

Signature of Patient/Parent/Guardian/or responsible party

Date