# PATIENT INFORMATION FORM

**TODAY'S DATE**_____ **ACCOUNT #** _____

**PLEASE PRINT AND COMPLETE ALL INFORMATION**

| PATIENT NAME | DATE OF BIRTH | CURRENT AGE | MARITAL STATUS<br>SINGLE _____<br>MARRIED _____<br>OTHER _____ |
|---|---|---|---|
| ADDRESS | | HOME PHONE | |
| NAME OF EMPLOYER | | WORK PHONE | OCCUPATION |
| EMPLOYEE'S ADDREESSS | | SOC. SEC. NO. | DRIVER LICENSE NO. |
| SPOUSE'S NAME | DATE OF BIRTH | SOC. SEC. NO. | WORK PHONE |
| DEPENDANT CHILDREN'S NAME | | | |
| NAME OF OTHER HOUSEHOLD MEMBERS | | | |
| NAME OF NEAREST RELATIVE NOT LIVING WITH YOU | | THEIR PHONE NO. | |

## MEDICAL INSURANCE INFORMATION

| | | |
|---|---|---|
| PRIMARY INSURANCE COMPANY | INSURANCE I.D. NUMBER | GROUP NO. |
| NAME OF INSURED | RELATIONSHIP TO PATIENT | PHONE NUMBER |
| ADDRESS OF INSURED | | INSURED'S DATE OF BIRTH |
| SECONDARY INSURANCE COMPANY | INSURANCE I.D. NUMBER | GROUP NO. |
| NAME OF THE INSURED | RELATIONSHIP TO PATIENT | PHONE NO. |
| ADDRESS OF THE INSURED | INSURED'S DATE OF BIRTH | |

## CONSENT TO MEDICAL CARE

**I,_____, am presenting myself as a patient to the Scranton Primary Health Care Center (SPHCC) and I voluntarily consent to the rendering of such care, including diagnostic procedures and medical by authorized agents and employees of the SPHCC, and by its medical staff, or their designees, as may in their professional judgment be deemed necessary or beneficial.**

**I acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment of my condition.**

_____ _____

**(Witness)** **(Patient's Signature)**

_____ _____

**(Date)** **(Time)**

***Because the above patient is an unemanciapted minor,_____ years of age or is unable to sign for the following reasons:**

_____

_____

**The above consent is given on the patient's behalf by:**

_____ _____

**(Witness)** **(Closest Relative or Legal Guardian)**

_____ _____

**(Date)** **(Time)**