

PATIENT INFORMATION FORM

TODAY'S DATE _____

ACCOUNT # _____

PLEASE PRINT AND COMPLETE ALL INFORMATION

PATIENT NAME	DATE OF BIRTH	CURRENT AGE	MARITAL STATUS SINGLE _____ MARRIED _____ OTHER _____
ADDRESS		HOME PHONE	
NAME OF EMPLOYER		WORK PHONE	OCCUPATION
EMPLOYEE'S ADDRESS		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 unemancipated 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)