PATIENT INFORMATION

Please Print Clearly

Today's Date ___________________________________

E-Mail Address___________________________________

Name____ ❑ Male ❑ Female _____________ _____________________
(First Name, Middle Initial, Last Name) (Age) (Birth date)

Address____ **Cell** ____________________ **Home** _____________________

City____ **State** _________ **Zip**_________________________________

Ethnicity: ❑ Hispanic ❑ Non-Hispanic **Preferred Language**: ❑ English ❑ Spanish ❑ _______________________________

Race: ❑ African/African-American ❑ Asian/Asian-American ❑ Caucasian/European-American ❑ _____________________________________

Marital Status: ❑ Single ❑Married ❑Divorced ❑Widowed **Social Security Number** _____________________________

Employer ____ **Occupation** ____

Business Address____ **Phone** ______________________________

City____ **State** __________ **Zip** _________________________________

INSURANCE POLICY HOLDER INFORMATION – IF NOT SELF

Name_______________________________________ _________________ _________________ ____________________
(First, Middle Initial, Last) (Birth date) (Relationship) (Social Security #)

Address____ Home ____________________ Cell ____________________

City____ State _________ Zip _________________________________

Employer__________________________________ City/State/ZIP_______________________Telephone # ___________________

If patient is under 18 yrs of age, please give information for the other parent/guardian:

Name___________________________________ _________________ _______________________ _________________________
(First, Middle Initial, Last) (Birth date) (Social Security #) (Employer)

Address____ Home ____________________ Cell ____________________

City____ State _________ Zip _________________________________

Employer__________________________________ City/State/ZIP_______________________Telephone # ___________________

In Case of Emergency, please notify:__________________________ **Relationship:** _____________ **Phone#**______________

Referred By:____ **Family Physician/Pediatrician** ____________________________

I hereby authorize the providers of Proponent Medical Group, Ltd. to furnish to the above insurance companies or to a designated attorney, all information which said insurance companies or attorney may request. I hereby assign to the providers of Proponent Medical Group, Ltd.all money to which I am entitled for medical and/or surgical expense relative to the service rendered by him, but not to exceed my indebtedness to said physician and/or surgeon. It is understood that any money received from the above named insurance company, over and above my indebtedness, will be refunded to the insurance or to me when my bill is paid in full. I understand I am financially responsible to said doctor for charges not covered by this assignment. I further agree in the event of non-payment, to bear the cost of collection, and/or Court cost and reasonable legal fees should this be required.

____ ____
Patient Signature (Parent/Guardian if under 18 yrs of age) Insurance Holder's Signature (if present and not patient)

Please Answer ALL of the following:

1) Current problem (reason for visit)?

2) When did symptom(s) first occur?

3) List any medication you are taking for this problem.

4) List **all other medication**, including vitamins, herbals, or supplements you are taking.