

**SUGAR LAKES FAMILY PRACTICE  
PATIENT INFORMATION  
ADULT**

**DATE:** \_\_\_\_\_ **DR:** \_\_\_\_\_ **ACCT#:** \_\_\_\_\_

**NAME(LAST):** \_\_\_\_\_ **(FIRST):** \_\_\_\_\_ **(MIDDLE):** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_ **(APT):** \_\_\_\_\_

**CITY:** \_\_\_\_\_ **STATE:** \_\_\_\_\_ **ZIP CODE** \_\_\_\_\_

**HOME TELEPHONE#( )** \_\_\_\_\_ **WORK#:( )** \_\_\_\_\_

**SS#:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_ **AGE:** \_\_\_\_\_

**EMPLOYER:** \_\_\_\_\_ **ADDRESS:** \_\_\_\_\_

**OCCUPATION:** \_\_\_\_\_

**MARITAL STATUS:** \_\_\_\_\_ **MALE:** \_\_\_\_\_ **FEMALE:** \_\_\_\_\_

**SPOUSE'S NAME:** \_\_\_\_\_ **SS#:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**SPOUSE'S EMPLOYER:** \_\_\_\_\_ **ADDRESS:** \_\_\_\_\_

CHILDREN'S NAME	DATE OF BIRTH	SOCIAL SECURITY#
_____	_____	_____
_____	_____	_____
_____	_____	_____

**EMERGENCY NAME:** \_\_\_\_\_ **PHONE#:** \_\_\_\_\_

**REFERRED BY:** \_\_\_\_\_ **PHONE#:** \_\_\_\_\_

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**INSURANCE NAME:** \_\_\_\_\_ -  
**ISURANCE ID#:** \_\_\_\_\_ **INSURANCE GROUP#:** \_\_\_\_\_  
**INSURED'S NAME:** \_\_\_\_\_ **EMPLOYER:** \_\_\_\_\_  
**INSURANCE ADDRESS:** \_\_\_\_\_  
**INSURANCE TELEPHONE#:( )** \_\_\_\_\_

I HEREBY AUTHORIZE DIRECT PAYMENT OF MEDICAL BENEFITS TO SUGAR LAKES FAMILY PRACTICE FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE COMPANY. I ALSO AUTHORIZE A RELEASE OF MY MEDICAL OR INCIDENTAL INFORMATION THAT MAY BE NECESSARY FOR EITHER MEDICAL CARE OR IN PROCESSING APPLICATION FOR FINANCIAL BENEFIT. I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT IS CORRECT. I AUTHORIZE RELEASE OF REPORTS ON REQUEST. I REQUEST THAT PAYMENT OF AUTHORIZED BENEFIT BE MADE ON MY BEHALF. A PHOTOCOPY OF THESE ASSIGNMENTS SHALL BE VALID AS THE ORIGINAL.

**PATIENT'S SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**PARENT/GUARDIAN:** \_\_\_\_\_ **DATE:** \_\_\_\_\_  
(Legal Guardian does not include step-parent unless authorized by the Court)

