SOUTHSIDE MEDICAL CARE

PATIENT INFORMATION- PLEASE PRINT CLEARLY

Patient's Name:_____ SS#: _____ - _____- _____

Birth Date: ____/____/_____ Sex: M or F Age: _____ Marital Status:_____

Guardian's Name if Minor: _____

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

Primary Phone: _____ Secondary Phone: _____

Email: _____

PHARMACY INFORMATION

Pharmacy Name: _____ Pharmacy Number: _____

Pharmacy Location:_____

INSURANCE INFORMATION

1. **Primary Insurance** _____
   Policy Holder's Name:_____ Relationship to Policy Holder:_____
   Policy Holder's Date of Birth: ____/____/_____ Policy Holder's SS#: _____ - _____- _____
   Policy #: _____ Group #: _____
2. **Secondary Insurance** _____
   Policy Holder's Name:_____ Relationship to Policy Holder:_____
   Policy Holder's Date of Birth: ____/____/_____ Policy Holder's SS#: _____ - _____- _____
   Policy #: _____ Group #: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone #:_____

ANY PERSON(S) SMC CAN RELEASE INFORMATION TO

Name: _____ Relationship: _____ Phone #:_____

Name: _____ Relationship: _____ Phone #:_____

___ DO NOT RELEASE MY INFORMATION TO ANYONE

MEDICAL CONSENT
ASSIGNMENT OF BENEFITS- RELEASE OF INFORMATION

I HEREBY, UNDERSIGNED AUTHORIZE THE PHYSICANS, PHYSICIAN ASSISTANTS AND/OR NURSE PRACTIONER AND STAFF AT SOUTHSIDE MEDICAL CARE TO PROVIDE MEDICAL CARE FOR THE ABOVE NAMED PATIENT. I ALSO, CONSENT TO THE RELEASE BY SOUTHSIDE MEDICAL CARE OF ANY AND ALL MEDICAL INFORMATION NECESSARY TO PROCESS ANY AND ALL INSURANCE CLAIMS ON MY BEHALF. I HEREBY WITH MY SIGNATURE ASSIGN AND AUTHORIZE MY INSURANCE CARRIER (S) TO MAKE PAYMENT DIRECTLY TO SOUTHSIDE MEDICAL CARE FOR ALL SERVICES RENDERED.

SIGNATURE OF PATIENT: _____ **DATE:** _____