



# Sanger Clinic

## PATIENT INFORMATION (Please Print)

Doctor: \_\_\_\_\_ Chart #: \_\_\_\_\_ Date: \_\_\_\_\_

**(Please complete information below)**

Location: \_\_\_\_\_

PATIENT NAME (Please Print)	LAST	FIRST	MIDDLE	SS #	BIRTH DATE	AGE	SEX M F	MARITAL STATUS S M D W
STREET ADDRESS			CITY/STATE		ZIP CODE		HOME PHONE #	
PATIENT EMPLOYER			ADDRESS/CITY/STATE		ZIP CODE		WORK PHONE #	
WHO REFERRED YOU TO THIS OFFICE? Full Name & Phone #				WHO IS YOUR FAMILY DOCTOR? Full Name & Phone #				
EMERGENCY CONTACT (Relationship)			ADDRESS/CITY/STATE		ZIP CODE		WORK & HOME PHONE #	
<b>PRIMARY INSURANCE (fill in below)</b>								
INSURANCE COMPANY NAME			TELEPHONE #	EFFECTIVE DATE	POLICY ID #		GROUP #	
POLICY HOLDER NAME			EMPLOYER		BUSINESS PHONE #			
POLICY HOLDER DATE OF BIRTH			POLICY HOLDER SS#		RELATIONSHIP TO PATIENT			
CLAIMS MAILING ADDRESS			CITY/STATE		ZIP CODE		TYPE OF POLICY: __PPO __HMO__POS	
<b>SECONDARY INSURANCE (fill in below)</b>								
INSURANCE COMPANY NAME			TELEPHONE #	EFFECTIVE DATE	POLICY ID #		GROUP #	
POLICY HOLDER NAME			EMPLOYER		BUSINESS PHONE #			
POLICY HOLDER DATE OF BIRTH			POLICY HOLDER SS#		RELATIONSHIP TO PATIENT			
CLAIMS MAILING ADDRESS			CITY/STATE		ZIP CODE		TYPE OF POLICY: __PPO __HMO__POS	
PERSON RESPONSIBLE FOR PAYMENT			ADDRESS/CITY/STATE			HOME PHONE #		
WERE YOU INJURED ON THE JOB? __YES __NO		DATE OF INJURY		CLAIM #	AUTO INVOLVED? DATE __YES __NO		NAME OF ATTORNEY	

### INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby assign payment of the medical and/or major medical benefits, if any, otherwise payable to me for this service, directly to the designated physician and/or the Sanger Clinic. This authorization is valid for any and all insurance claims filed for me by the Sanger Clinic to the insurance companies listed above. This authorization is valid from this date until written notice of cancellation is received in the offices of the Sanger Clinic.

**I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO THE SANGER CLINIC AND/OR DESIGNATED PHYSICIAN FOR CHARGES NOT COVERED OR PAID BY THIS ASSIGNMENT.**

I hereby authorize the designated physician to release any information acquired in the course of my examination and treatment to the insurance company(ies) listed above, and any other physician or health care facility where the Sanger Clinic may refer me for further care.

\_\_\_\_\_  
Signed Insurance Holder Date Signed Responsible Individual Date