

# Patient Information Sheet

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## HEAD OF HOUSEHOLD INFORMATION

Head of  
Household:

Occupation

Social  
Security #:

Sex:

Date of Birth:

Address:

Home  
phone #:

City, St.:

Zip:

Employer's  
Name:

Employer's  
Address:

Employer's  
phone #:

Employer's  
City, St.:

Employer's Zip:

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## PATIENT INFORMATION

Patient's  
Legal Name:

Nickname:

Sex:

Date of  
Birth

Marital Status

Relationship  
to head of  
household

Social Security #:

Employer  
Name:

Employer phone #:

Employer  
Address:

Employer's  
City, St.:

Zip:

Referring  
Physician

Allergies:

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**EMERGENCY INFORMATION**

Other  
contact not  
living with  
you:

Home  
Phone #:

Work phone #:

Address

City, St.

Zip:

Patient  
relationship  
to other  
contact:

If patient is a child,  
parent name:

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**INSURANCE INFORMATION**

Primary  
Insurance:

Subscriber:

ID#:

Relationship to subscriber:

Secondary  
Insurance:

Subscriber:

ID#:

Relationship to subscriber:

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**OTHER FAMILY MEMBERS:**

Name:

Date of Birth:

Name:

Date of Birth:

Name:

Date of Birth

Name:

Date of Birth:

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I understand that it is my responsibility that any incurred charges are paid.

To the extent necessary to determine liability for payment to obtain reimbursement, process claim forms, I authorize the release of any medical information necessary to process claims.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and other health plans to Acumen Medical Practice, Somewhere, OR 12345

This assignment will remain in effect until revoked by me in writing, a photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure the payment.

Signature:

Date: