

GEORGE H. SANDERS, M.D., APC

TODAY'S DATE:

PATIENT INFORMATION:

Single Married Other

NAME: _____ BIRTHDATE: ___/___/___ SEX: M F
first middle last

ADDRESS: _____
number street ZIP: _____
city state

DAYTIME PHONE:(____) _____ EVENING PHONE:(____) _____ E-MAIL ADDRESS: _____

ARE YOU: EMPLOYED NOT EMPLOYED FULL-TIME STUDENT PART-TIME STUDENT CHILD
IF ADULT,
EMPLOYER: _____ OCCUPATION: _____

WORK ADDRESS: _____
number street city state zip

SOCIAL SECURITY NUMBER: _____ DRIVER'S LICENSE NUMBER: _____

RESPONSIBLE PARTY INFORMATION:

RELATIONSHIP TO PATIENT: SELF SPOUSE PARENT OTHER

NAME: _____ BIRTHDATE: ___/___/___ SEX: M F
first middle last

ADDRESS: _____
number street ZIP: _____
city state

DAYTIME PHONE:(____) _____ EVENING PHONE:(____) _____ WORK PHONE:(____) _____

IS THE RESPONSIBLE PARTY: EMPLOYED NOT EMPLOYED FULL-TIME STUDENT PART-TIME STUDENT
IF EMPLOYED,
EMPLOYER: _____ OCCUPATION: _____

WORK ADDRESS: _____
number street city state zip

SOCIAL SECURITY NUMBER: _____ DRIVER'S LICENSE NUMBER: _____

INSURANCE INFORMATION:

PRIMARY INSURANCE: _____ SUBSCRIBER'S NAME: _____

SUBSCRIBER'S NUMBER: _____ GROUP NUMBER: _____ POLICY NUMBER: _____

SECONDARY INSURANCE: _____ SUBSCRIBER'S NAME: _____

SUBSCRIBER'S NUMBER: _____ GROUP NUMBER: _____ POLICY NUMBER: _____

DO YOU HAVE ANOTHER HEALTH BENEFIT PLAN? YES NO
IS YOUR CONDITION RELATED TO: EMPLOYMENT AUTO ACCIDENT OTHER ACCIDENT

WHO REFERRED YOU TO OUR OFFICE? _____ REASON FOR THIS VISIT: COSMETIC CONSULT OTHER

NAME OF YOUR FAMILY DOCTOR: _____
first name last name phone # or city where practice is located

IN CASE OF AN EMERGENCY, NOTIFY: _____
RELATIONSHIP: _____ DAYTIME PHONE: (____) _____

I authorize you to give me reasonable & proper medical care by today's standards. I, the patient or responsible party, authorize release of medical information for the purpose of processing medical claims.

I also authorize my insurance company to pay benefits directly to George H. Sanders, M.D., A Prof. Corp.
I authorize Dr. Sanders to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

SIGNATURE: _____ DATE: _____