HEALTH SERVICE SYSTEMS, INC.

PATIENT INFORMATION DATA

Name: ______________________ **Birth Date:** ____/____/____ **Sex** ☐ M ☐ F

Address: ______________________ City: ______________ State: ________ Zip: __________

SS #: ______-______-______ **Marial Status:** ☐ S ☐ M ☐ W ☐ D Spouse Name: ______________________

Phone #: Home: ( ) ______-________ Cellular: ( ) ______-________ **E-mail:** ______________________

Preferred Communication (Choose one): ☐ **Phone** ☐ **Text** ☐ **E-mail** **Preferred Language:** ☐ **English** ☐ **Spanish**

Race:
- ☐ White
- ☐ Black/African American
- ☐ Other: __________
- ☐ Declined

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic
- ☐ Other: __________
- ☐ Declined

How were you referred? :
- ☐ Patient
- ☐ Doctor______________
- ☐ Internet______________
- ☐ Other: ______________

Pharmacy (name, location, phone #): ______________________________________

____

Mail Order Pharmacy: ☐ **No** ☐ **Yes** ______________________________________

PRIMARY INSURANCE INFORMATION

Insurance Company: ______________________________________

Plan ID#: ______________________ Group#: ______________________

Subscriber Name: ______________________ **Subscriber DOB:** ______________________

Subscriber SS#: ______________________ **Relationship to Patient:** ______________________

SECONDARY INSURANCE INFORMATION

Insurance Company: ______________________________________

Plan ID#: ______________________ Group#: ______________________

Subscriber Name: ______________________ **Subscriber DOB:** ______________________

Subscriber SS#: ______________________ **Relationship to Patient:** ______________________

CONTACT FOR RESULTS

I authorize Sanitas to contact for results:

- ☐ Myself only
- ☐ Home
- ☐ Cell
- ☐ Other: ( ) ______-________

☐ Other:
Name: ______________________
Relationship: ______________________
Phone #: ( ) ______-__________

Answering Machine: ☐ **No** ☐ **Yes**

Did you sustain an injury at work? ☐ No ☐ Yes ***Are your injuries accident related?*** ☐ No ☐ Yes

EMERGENCY CONTACT:

Name: ______________________ Relationship: ______________ Phone#: ______________

AUTHORIZATION TO TREAT:

I hereby authorize my insurance benefits to pay directly to Health Service Systems, Inc., realizing I am responsible to pay non-covered services. I authorize the release of medical information to insurance carriers.

______________________________ ______________________________

Signature *Date*