

GASHLAND CLINIC PATIENT INFORMATION FORM

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PATIENT INFORMATION (PLEASE PRINT)

FIRST NAME _____ M _____ LAST NAME _____
STREET _____ APT _____ CITY _____ STATE _____ ZIP _____
DATE OF BIRTH _____ AGE _____ SEX _____ SOCIAL SECURITY _____ - _____ - _____
MARITAL STATUS _____ HOME PHONE _____ CELL PHONE _____
EMPLOYER _____ WORK PHONE _____
EMERGENCY CONTACT _____ PHONE _____

Primary Party Information

FIRST NAME _____ M _____ LAST NAME _____ DOB _____ SEX _____
STREET _____ APT _____ CITY _____ STATE _____ ZIP _____
HOME PHONE _____ CELL PHONE _____ WORK PHONE _____
EMPLOYER _____ SOCIAL SECURITY _____ - _____ - _____

Secondary Party Information

FIRST NAME _____ M _____ LAST NAME _____ DOB _____ SEX _____
STREET _____ APT _____ CITY _____ STATE _____ ZIP _____
HOME PHONE _____ CELL PHONE _____ WORK PHONE _____
EMPLOYER _____ SOCIAL SECURITY _____ - _____ - _____

Responsible Party Information

FIRST NAME _____ M _____ LAST NAME _____ DOB _____ SEX _____
STREET _____ APT _____ CITY _____ STATE _____ ZIP _____
HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

AUTHORIZATION

I HEREBY AUTHORIZE GASHLAND CLINIC TO FURNISH ALL NECESSARY MEDICAL INFORMATION CONCERNING MY CARE AND TREATMENT, OR MY FAMILY'S CARE AND TREATMENT, TO MY INSURANCE COMPANY. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN

DATE