



PATIENT INFORMATION SHEET

SOCIAL SECURITY #: _____ DATE OF BIRTH: ____/____/____ SEX: M F

PATIENT'S NAME: Last _____ First _____ MI _____

DO YOU HAVE A LIVING WILL? Y N

LOCAL ADDRESS: _____ City _____ State/Zip _____

LOCAL PHONE: (____) _____ OUT OF STATE PHONE: (____) _____

CELL PHONE: (____) _____ eMAIL ADDRESS _____

OUT OF STATE ADDRESS: _____ City _____ State/Zip _____

EMPLOYER: _____ EMPLOYER'S PHONE: _____

MARITAL STATUS: MARRIED SINGLE WIDOWED DIVORCED

SPOUSE'S NAME: Last _____ First _____ MI _____ DATE OF BIRTH: ____/____/____

SPOUSE'S SOCIAL SECURITY #: _____

SPOUSE'S EMPLOYER: _____ SPOUSE'S EMPLOYER'S PHONE: _____

NAME & PHONE NUMBER OF NEAREST RELATIVE NOT LIVING WITH YOU:

NAME: _____ PHONE NUMBER: _____

PLEASE PRESENT UP-TO-DATE INSURANCE CARDS TO RECEPTIONIST

FAMILY PHYSICIAN'S NAME: _____ PHONE: _____

REFERRING PHYSICIAN'S NAME: _____ PHONE: _____

DOES YOUR DOCTOR NEED TO AUTHORIZE THIS VISIT FOR YOUR INSURANCE? Y N

I HEREBY AUTHORIZE SAMSON SHOWALTER LEPORE-VASCULAR SPECIALISTS TO FURNISH INFORMATION TO INSURANCE CARRIERS, REFERRING PHYSICIANS, OR OTHER PERSONS AS I DIRECT, CONCERNING MY CONDITION. FURTHER, I GIVE PERMISSION FOR ANY OF MY MEDICAL RECORDS, X-RAYS, OR OTHER HOSPITAL TESTS AND/OR ANY ADDITIONAL INFORMATION CONTAINED IN MY MEDICAL RECORDS TO BE SENT TO SAMSON SHOWALTER LEPORE-VASCULAR SPECIALISTS BY MAIL, FAX OR EMAIL. I GIVE MY PERMISSION FOR THE RELEASE OF ANY HIV INFORMATION. I ALSO ASSIGN TO SAMSON SHOWALTER LEPORE-VASCULAR SPECIALISTS ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENT(S). I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

DATE: _____

SIGNATURE: _____