TEMPLE HEALTH

_____UPDATE _____NEW

PATIENT INFORMATION SHEET

(PLEASE PRINT CLEARLY)

PERSONAL INFORMATION

LAST FIRST MIDDLE

AKA OR MAIDEN NAME

SOCIAL SECURITY # SEX: M F

DATE OF BIRTH **MOTHER'S FIRST NAME**

EMERGENCY CONTACT NAME

EMERGENCY CONTACT PHONE NUMBER

TUHS EMPLOYEE OR FAMILY (INDICATE STATUS)

MARITAL STATUS:
_____MARRIED _____SINGLE _____DIVORCED
_____WIDOWED _____SEPARATED

MINORS:
FATHER'S NAME: _____

MOTHER'S NAME: _____

LEGAL GUARDIAN: _____

RACE*:
____ASIAN OR ASIAN INDIAN ____ CAUCASIAN
____AFRICAN AMERICAN ____NATIVE AMERICAN
____NATIVE HAWAIAN ____OTHER
____**REFUSE TO ANSWER**

ETHNICITY*:
HISPANIC OR LATINO (SPANISH ORIGIN) YES NO

PREFERRED LANGUAGE: _____

*it is not mandatory to answer this question, but for statistical purposes, your answers would be appreciated.

RESPONSIBLE PARTY (LEGAL)

NAME

RELATION TO RESPONSIBLE PARTY

ADDRESS (IF DIFFERENT FROM PATIENT)

PHONE NUMBER

E-MAIL ADDRESS

ADVANCE DIRECTIVES ON FILE

POWER OF ATTORNEY

CONTACT INFORMATION

FIRST LINE OF ADDRESS

SECOND LINE OF ADDRESS OR PO BOX

CITY STATE ZIP

( )
PRIMARY PHONE NUMBER

( )
SECONDARY PHONE NUMBER

( )
WORK PHONE NUMBER

E-MAIL ADDRESS

PATIENT EMPLOYMENT INFORMATION

EMPLOYER NAME

FIRST LINE OF ADDRESS

SECOND LINE OF ADDRESS OR PO BOX

CITY STATE ZIP

( )
PHONE NUMBER

OCCUPATION

PRIMARY CARE PHYSICIAN

NAME OF PCP

FIRST LINE OF ADDRESS

SECOND LINE OF ADDRESS OR PO BOX

CITY STATE ZIP

( )
PHONE NUMBER

( )
FAX NUMBER

HOW DID YOU HEAR ABOUT OUR PRACTICE?

_____
_____
_____

PATIENT SIGNATURE _____

DATE _____/_____/_____

_____**UPDATE** _____**NEW**

PATIENT NAME

DATE OF BIRTH

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY

MEMBER ID NUMBER

GROUP NUMBER EFFECTIVE DATE

SUBSCRIBER'S NAME

SUBSCRIBER'S DATE OF BIRTH SEX

INSURANCE COMPANY PHONE NUMBER

SECONDARY INSURANCE

NAME OF INSURANCE COMPANY

MEMBER ID NUMBER

GROUP NUMBER EFFECTIVE DATE

SUBSCRIBER'S NAME

SUBSCRIBER'S DATE OF BIRTH SEX

INSURANCE COMPANY PHONE NUMBER

MEDICAID

RECIPIENT ID

CARD NUMBER EFFECTIVE DATE

AUTO ACCIDENT CLAIM INFORMATION

NAME OF INSURANCE COMPANY

POLICY NUMBER

CLAIM NUMBER

DATE OF ACCIDENT

CLAIM ADJUSTER'S NAME

MAILING ADDRESS FOR CLAIMS

CLAIM ADJUSTER'S PHONE NUMBER AND EXTENSION

WORKER'S COMP CLAIM INFORMATION

NAME OF INSURANCE COMPANY

EMPLOYER'S NAME

EMPLOYER'S ADDRESS

EMPLOYER'S PHONE NUMBER

CLAIM NUMBER

DATE OF INJURY

CLAIM ADJUSTER'S NAME

MAILING ADDRESS FOR CLAIMS

CLAIM ADJUSTER'S PHONE NUMBER AND EXTENSION