DATE: / /

O'Connor Medical Group

Patient Information Form

Patient Information Form

Patient Name: DOB: / / SS#:

Patient Street Address: City/State/Zip:

Home Phone #: ( ) - Work Phone #: ( ) -

Cell Phone #: ( ) - Marital Status:

Emergency Contact: Contact's Phone #: ( ) -

Pharmacy: Pharmacy Phone #: ( ) -

Pharmacy Address:

Do you have separate insurance for pharmacy coverage? ☐ NO ☐ YES

Subscriber Name: (Guarantor/Responsible Party):

Insurance ID#: SS#: DOB:

Subscriber Address: City/State/Zip:

Home Phone #: ( ) - Work #: ( ) -

Guarantor Employer Name & Address:

Patient's Primary Insurance: ID#:

Secondary Insurance (Include Medicaid): ID#:

Have you ever seen Dr. O'Connor before? ☐ NO ☐ YES

Below is an authorization to release information and assignment of benefits.

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Signature DATE:

I hereby authorize O'Connor Medical to apply for benefits on my behalf for covered services rendered. I request that payment from my insurance company be made directly to O'Connor Medical Group. I certify that the information I have reported with regard to my insurance coverage is correct. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time, in writing.

Signature DATE:

Health Care Information

O'Connor Medical Group

Patient Name: ______________________________ **DOB:** ______________

To better serve all of your health care needs, we are requesting the following information.

1. **Emergency Contact**

   Name: ____________ Relationship: ____________ Phone Number: ____________

   Name: ____________ Relationship: ____________ Phone Number: ____________

   May we share your medical information with the above contacts? **YES** **NO**

2. **Primary Language Spoken**

   ____

3. **Race**

   ☐ White ☐ Asian

   ☐ Black/African American ☐ Native Hawaiian/Pacific

   ☐ American Indian/Alaska Native ☐ Other: ______________

4. **Ethnicity**

   ☐ Spanish/Hispanic Origin

   ☐ Unknown/Other

5. **Health Care Proxy Information Given?** (PLEASE INITIAL) ______

Signature ______________________________

*** (If under 18 years old, parent/guardian must sign)***

DATE: ______________