

PATIENT HISTORY INFORMATION

(PLEASE PRINT) PLEASE ANSWER ALL QUESTIONS

Name _____ Birth date _____ Age _____ SS# _____

Address _____ Apt # _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Office Address _____ Referred By _____

Phone number to use for biopsy/lab work results _____ Can we leave a message? Yes No

Pharmacy Name _____ Address _____ Phone _____

Sex: Male Female Marital Status: Single Married Divorced Widowed

If married – Name of Spouse _____ Spouse Birth date _____ Spouse SS# _____

If patient is under the age of 18.

Name of Mother & Father or legal Guardian _____

Name of responsible party _____ Relationship to Child _____

Address of responsible party _____ SS# _____

In case of emergency: next of kin not living with you

Emergency Contact Name _____ Phone Number _____

Name of Employer _____ Address _____ Phone _____

Name of Spouse or Parent's Employer _____ Address _____ Phone _____

Insurance (Please complete all fields)

Primary

Insurance Name _____

Subscriber Name _____

Subscriber Date of Birth _____

ID Number _____

Group Number _____

Effective Date _____

Relationship of patient to Subscriber _____

Secondary

Insurance Name _____

Subscriber Name _____

Subscriber Date of Birth _____

ID Number _____

Group Number _____

Effective Date _____

Relationship of patient to Subscriber _____

Authorization To Pay Insurance Benefits and Release Information To Insurance Company

I hereby authorize my Doctor and/or such assistants as may be selected by him/her to perform such procedures as are necessary and desirable, including but not limited to the services of Pathologist or a laboratory. The authorization granted in the paragraph shall extend to remedying conditions that are not known to my doctor at the time the procedure commences.

I hereby authorize payment directly to William M. Parsley, MD, PSC. I understand I am financially responsible to the above physicians for charges not covered by this authorization.

I authorize Dr. William M Parsley, MD, PSC to release information required to complete my insurance claim, and if necessary I authorize my doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Signature of Patient _____ Date _____

(**If minor, signature of parent or legal guardian)

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