

Date: _____

Patient Information Sheet

Seminar: _____
date

First Name: _____ Last Name: _____ DOB _____

Address: _____ City, St: _____ Zip _____

Home # () _____ Cell # () _____ Work # () _____

Social Security Number _____ - _____ - _____ Marital status _____

E-mail address _____ Employer _____

Primary Care Physician _____ phone number _____

How did you hear about us? () Newspaper Ad () Website () Flyer/Mail () Radio () TV
() Family () Friend () Dr. _____ () Other _____

Ht: _____ ' _____ Wt: _____ lbs. Please all that apply: () High Blood pressure
() High Cholesterol () Sleep Apnea () Osteoarthritis () Swelling in legs () Asthma
() Urinary Stress Incontinence () Depression () Back Pain () Acid Reflux () Diabetes

Insurance Company _____ Please circle HMO PPO * Phone # _____

Name of insured (if different) _____ Date of birth _____

Employer _____ Policy # _____ Group # _____

Secondary Ins _____ Policy # _____ Group # _____

Authorization for Release of Medical Information / consent to use above information to verify insurance coverage:

I hereby grant Methodist Healthcare permission to request information related to my care from the following providers:

(Please list names of Physicians you are currently under the care of and phone numbers if available)

I understand that this release of information authorization shall remain in effect unless revoked by me at any time by submitting a written request to our office.

Signature of patient or legal guardian _____

_____ Date