Stephen R. Burton MD PC

PATIENT INFORMATION

Patient Name

LAST_______________________________________FIRST_________________________MI______ SSN_______________________

ADDRESS____CITY________________STATE_____ZIP____________

DATE OF BIRTH___________________AGE______SEX- M F HOME #_________________CELL/WK #__________________

E-MAIL ADDRESS (PARENT'S E-MAIL IF UNDER 18): ____

RACE: ☐ Asian ☐ Other Race ☐ African American ☐ American Indian OR Alaskan Native ☐ Caucasian ☐ Native Hawaiian OR Other Pacific Islander

ETHNICITY: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ☐ Native Hawaiian

MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

IF UNDER 18: PARENT(S) NAME____

FINANCIALLY RESPONSIBLE NAME & ADDRESS IF DIFFERENT FROM ABOVE:

____

REFERRING DOCTOR (First, Last)____

REFERRING DOCTOR ADDRESS____PHONE #__________________________

FAMILY DOCTOR (First, Last)____

FAMILY DOCTOR ADDRESS____PHONE #_________________________

EMERGENCY CONTACT ____ PHONE # _________________________

RELATION TO PATIENT____

Insurance Information	Primary	Secondary
Name of Company	________________________________	________________________________
Group And Policy #	________________________________	________________________________
Subscriber's name	________________________________	________________________________
Subscriber's DOB	________________________________	________________________________
Employer's name	______________________________	Employer's name ______________________________
Employer's address	______________________________	Employer's address ______________________________

Specialty Office Copay: ________ (If you do not know your copay please call your insurance before you arrive for your appt)

I give my permission to:

YES NO Leave a message with test results on answering machine TEL#____

YES NO Leave a message requesting a return call on my home answering machine.

YES NO Leave a message requesting a return call on my work phone.

YES NO FAX test result/information regarding my condition to FAX#____

Release medical information regarding myself to the following persons____

____

Office use only:

Initials: _________ Date:_________ Initials: _________ Date: _________ Initials: _________ Date: __________