SGCMH PHYSICIAN CLINICS
PATIENT INFORMATION

(This information is necessary for our files & will be considered confidential)

PATIENT'S FULL NAME_____ DATE_____

ADDRESS_____ CITY_____

STATE _____ ZIP CODE _____ DATE OF BIRTH _____

(If mailing address is different, please indicate): _____

HOME PHONE #_____ ALT. PHONE #_____ CELL WORK

RACE _____ ETHNICITY ☐ Hispanic or Latino ☐ Not Hispanic or Latino

PREFERRED LANGUAGE _____

EMPLOYER NAME: _____ EMPLOYER PHONE: _____

EMPLOYER ADDRESS/STATE/ZIP: _____

SEX: M F SOCIAL SECURITY #_____ MARITAL STATUS: S M W D

EMAIL ADDRESS: _____

EMERGENCY CONTACT:_____ RELATIONSHIP:_____

EMERGENCY CONTACT PHONE #_____

NEXT OF KIN_____RELATIONSHIP_____

NEXT OF KIN ADDRESS/PHONE #_____

PLEASE CHECK HERE IF YOU WOULD LIKE TO BE ON OUR MAILING LIST ☐

HOW DID YOU HEAR ABOUT US? ☐ Family ☐ Friend ☐ Newspaper ☐ Radio ☐ Other: _____

PRIMARY INSURANCE INFORMATION

NAME OF INSURANCE_____

SUBSCRIBER NAME_____ RELATIONSHIP TO PATIENT_____

(Name listed on ins. card)

SUBSCRIBER SSN#_____SUBSCRIBER DATE OF BIRTH _____

PREFERRED LAB (if applicable): _____

Ste. Genevieve County Memorial Hospital Physician Clinics do not deny any benefits or service because of race, color, national origin, age, gender, disability, religious or political beliefs. If you feel you have been discriminated against, you may file a Complaint of Discrimination with the Manager of this facility. You will not suffer any penalty because you file a complaint.

I hereby assign payment of authorized medical benefits to include major medical benefits to which I am entitled; to be made on my behalf to SGCMH Physician Clinics for any services furnished me by my practitioner. I authorize release of medical information needed to determine these benefits payable to related services. I understand that I am financially responsible for all charges whether or not paid by said insurance.

In addition, I agree to pay any additional charges related to the cost of collection (including but not limited to, collection agency fees, reasonable attorney fees and court costs), in the event that I would fail to pay my bill.

PATIENT SIGNATURE_____ DATE_____

(OR LEGAL GUARDIAN IF MINOR)