FAMILY MEDICINE SOLUTIONS, P.A.

PATIENT INFORMATION SHEET

SULTAN H. RAHAMAN, M.D.

Date: _____

PATIENT NAME: _____
(LAST) (FIRST) (INITIAL)

ADDRESS: _____
(NO.) (STREET) (CITY & STATE) (ZIP CODE)

PATIENT'S SEX: ☐ MALE ☐ FEMALE DATE OF BIRTH: _____ AGE: _____
MARITAL STATUS: ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED

SPOUSE'S NAME: _____

PT.'S SOCIAL SECURITY #: _____ DRIVER'S LICENSE #: _____

PT.'S OCCUPATION: _____ NAME OF EMPLOYER: _____

HOME PHONE #: _____ BUSINESS PHONE: _____

EMAIL ADDRESS: _____

IN EMERGENCY CONTACT: _____ PHONE: _____
(NAME) (RELATION)

IF PATIENT IS A MINOR, PLEASE FILL OUT THIS SECTION.

FATHER'S NAME: _____ OCCUPATION: _____

FATHER'S ADDRESS: _____
(NO.) (STREET) (CITY & STATE) (ZIP CODE)

MOTHER'S NAME: _____ PHONE: _____

MOTHER'S ADDRESS: _____
(NO.) (STREET) (CITY & STATE) (ZIP CODE

PREVIOUS DOCTOR: _____

REFERRAL SOURCE: ☐ INTERNET ☐ INSURANCE CO. ☐ FRIEND/ RELATIVE ☐ PHYSICIAN: _____

IF SEEN IN HOSPITAL OR EMERGENCY ROOM: _____
(NAME OF HOSPITAL) (DATE SEEN IN HOSPITAL)

COMMERCIAL INSURANCE POLICY NO. 1

INSURED'S NAME: _____

INSURED'S I.D. NO. (INCLUDE ANY LETTERS) _____

INSURED'S GROUP NO. (AND GROUP NAME) _____

INSURANCE CO. NAME _____

ADDRESS FOR MAILING CLAIMS _____

CITY STATE ZIP

COMMERCIAL INSURANCE POLICY NO. 2

INSURED'S NAME: _____

INSURED'S I.D. NO. (INCLUDE ANY LETTERS) _____

INSURED'S GROUP NO. (AND GROUP NAME) _____

INSURANCE CO. NAME _____

ADDRESS FOR MAILING CLAIMS _____

CITY STATE ZIP

ASSIGNMENT OF BENEFITS/ RELEASE OF INFORMATION

I hereby assign all insurance benefits to which I am entitled, including Medicare, Medicaid, private insurance, major medical benefits and any other health plans to the assigned physician. This assignment will remain in effect until revoked by me in writing. I understand that I am **financially responsible** for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information, including HIV, substance abuse or psychiatric information which may be found in the record and is necessary to secure payment.

Patient or Responsible Party: _____ Date: _____