

HOSA MEDICAL OFFICE

PATIENT DATA SHEET

Patient's Name _____
Last First Middle

Address _____

City _____ State _____ Zip _____

E-mail _____

Date of Birth _____ Social Security # _____

Home Phone _____ Pager/Cell # _____

Employer _____ Work phone _____

Occupation _____

Address _____

INSURANCE INFORMATION

Subscriber's Name _____

Insurance Company _____

Policy Number _____ Group Number _____ Union/Local _____

If Group Insurance, Name of Policy Holder (e.g., employer, union) _____

Insured's ID or Medicare Number (include any letters) _____

Effective Date of Insurance _____ Coverage _____

Exclusions or Exceptions _____

ADDITIONAL COVERAGE

Other Health Insurance? _____ Yes _____ No _____

Copy of Insurance Card(s)? _____ Yes _____ No _____

If Yes, Name of Policy Holder _____ Company _____

Plan Name and Address _____

Policy or Medical Assistance Number _____

AUTHORIZATION

I hereby authorize the physician indicated above to furnish information to insurance carriers concerning this illness/accident and I hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance.

Responsible Party Date