

Linda Sewell MD, PC

Name: _____ Social Security # _____ - _____ - _____ DOB _____
Last First Middle

Marital Status (check one): Single ___ Married ___ Divorced ___ Separated ___ Domestic Partner ___

Race: Black American Indian /Alaska Native Asian White Native Hawaiian/Pacific Islander

Language: English French Spanish German Italian Mandarin Vietnamese Ethnicity: Hispanic/Latino non-hispanic/Latino white other

Mailing address: _____
Street City State Zip

Home Phone () _____ Cell phone: () _____ Work phone () _____

Employer: _____ Occupation _____

Employer address _____
Street City State Zip

Spouse: _____ Social Security # _____ - _____ - _____ DOB _____ Spouse cell _____
Any restrictions: none message only

Spouse Employer _____ Spouse work phone: _____

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If someone other than the PATIENT is responsible for payment, complete the following:

Name of the responsible party _____ Address _____

Relationship to patient _____ Social Security # _____ - _____ - _____ Home phone: _____

Employer _____ Address _____ Work phone: _____ DOB: _____

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In case of EMERGENCY:

Relative to contact (other than spouse) _____ Phone# _____

Any restrictions: none message only relationship to pt _____

Other person to contact (not relative) _____ Phone # _____

Any restrictions: none message only relationship to pt _____

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How do you intend to pay? Cash ___ Check ___ Credit card ___ Insurance ___ Medicare ___ OHP ___

Primary insurance: _____ Address _____

Phone# _____ Name of insured: _____ Relationship: _____

Policy # _____ Group # _____ DOB: _____

Secondary insurance: _____ Address _____

Phone# _____ Name of insured: _____ Relationship: _____

Policy # _____ Group # _____ DOB: _____

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Please sign and return to the receptionist.

I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to release information necessary to secure payment. No show fees and collection fees are explained in the welcome letter.

I also authorize Linda Sewell MD to render treatment for the above named patient and all insurance payments be made to the provider for services rendered. I further permit the medical provider to release information to the Social Security Administration and other medical providers that may coordinate treatment for the above named patient.

Signature: _____ Date: _____