PATIENT'S INFORMATION SHEET **TODAY'S DATE________________**

PATIENTS NAME:___________________________________**SOCIAL SECURITY**________________
(FIRST) (MI) (LAST)

ADDRESS:____
(City) (State) (Zip Code)

SEX: *MALE__ FEMALE__* **DOB**:__________**MARITAL STATUS**:______**HOME PHONE**:(____)___________

OCCUPATION: ____**WORK PHONE**:(___)____________

EMPLOYER: ____

WORK ADDRESS:____
(City) (State) (Zip Code)

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FINANCIALLY RESPONSIBLE PERSON:_________________**RELATIONSHIP TO PATIENT**_______
(*INSURANCE IN THE NAME OF?)*

OCCUPATION:____________**SOCIAL SECURITY#**______________**HOME PHONE:**_____________

EMPLOYED BY:____________________________________**WORK PHONE:**____________________

WORK ADDRESS:____

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WHO REFERRED YOU TO US?__________________________**PHONE NUMBER: (___)**___________

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PRIMARY INSURANCE:____

POLICY IN NAME OF:____________________**POLICY#**_______________**GROUP#**______________

INSURANCE CO. ADDRESS:____

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SECONDARY INSURANCE:____

POLICY HOLDER______________________**POLICY#**_________________**GROUP#**______________

INSURANCE CO. ADDRESS:____

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SPOUSE/PARENT/FAMILY CONTACT IN CASE OF EMERGENCY:_____________________________

HOME PHONE#___________________ **WORK PHONE#**_______________________________________

WE NEED ONE OTHER E**MERGENCY CONTACT PERSON,** ***OTHER THAN A HOUSEHOLD MEMBER***

NAME:__________________________________**RELATIONSHIP TO PATIENT**__________________

PHONE NUMBER: (___)____

Msword.pt.info.sheet
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DAINTY JACKSON, D.O.

Board Certified Family Physician

10 St. Patrick Drive
Suite 502
Waldorf, MD 20603
Tel: 301-885-3350
Fax: 301-885-3352

Assignment of Insurance Benefits

I hereby authorize the release of any information relating to all claims for benefits submitted on my behalf. I agree and acknowledge that my signature on this document authorized Dainty Jackson, DO to submit claims for benefits for services rendered, without obtaining my signature on each and every claim to be submitted for myself, and that I will be bound by this signature as though the undersigned had personally signed this particular claim.

I, _____ hereby authorized my insurance company to pay and hereby assign directly to Dainty Jackson, DO all benefits, if any. I understand I am financially responsible for all charged incurred, including non-covered expenses (i.e.: deductibles and co-payments as per my insurance policy.) I further acknowledge that any insurance benefits, when receive by and paid to Dainty Jackson, DO will be credited to my account, in accordance with the above assignment.

_____ _____

Signature of Subscriber Date