SUZANNE MILLS, M.D.
PATIENT INFORMATION SHEET

PATIENT

PATIENT NAME: _____
LAST FIRST MIDDLE

DATE OF BIRTH: _____ _____ **SEX:** M ☐ F ☐

FAMILY & CONTACT INFORMATION

☐ **FATHER:** _____ **DOB:** _____

ADDRESS: _____
CITY ZIP

HM PHONE: _(_____)_____ **CELL PHONE:** _(_____)_____

EMPLOYER: _____ **PHONE NO.:** _(_____)_____

SOC SEC NO.: _____ **EMAIL :** _____

☐ **MOTHER :** _____ **DOB:** _____

ADDRESS: _____
CITY ZIP

HM PHONE: _(_____)_____ **CELL PHONE:** _(_____)_____

EMPLOYER: _____ **PHONE NO.:** _(_____)_____

SOC SEC NO.: _____ **EMAIL:** _____

*If parents are divorced, please check which parent child lives with.

EMERGENCY CONTACT: _____ **PHONE NO.:** _____

SIBLINGS NAMES	DOB	SIBLINGS NAMES	DOB
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

INSURANCE

PRIMARY INSURANCE NAME: _____

SUBSCRIBER NAME: _____ **ID NO.:** _____

GROUP NO.: _____ **EFFECTIVE DATE:** _____

The undersigned agrees that all services are rendered on a paid basis only. Our policy is to collect for services at the time they are rendered. If collection becomes necessary, the undersigned shall pay all reasonable costs. We will bill insurance for those companies that we have a contractual obligation to do so. The undersigned agrees to authorize insurance benefits to be paid directly to the physician. The undersigned is responsible for all non-covered services. The undersigned authorizes the physician to provide any information required to process claims for benefits.

_____ _____
SIGNATURE OF PARENT OR GUARDIAN DATE

Who referred you to this office? _____