

DR. SAMUEL B. RUSH

PATIENT DEMOGRAPHICS

DATE \_\_\_\_\_

PATIENT \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_

MARRIED \_\_\_\_\_ SINGLE \_\_\_\_\_ WIDOWED \_\_\_\_\_ DIVORCED \_\_\_\_\_ SEPERATED \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

HOME PHONE \_\_\_\_\_ CELL \_\_\_\_\_

PATIENT EMPLOYED BY \_\_\_\_\_ OCCUPATION \_\_\_\_\_

BUSINESS ADDRESS \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_ BUSINESS PHONE \_\_\_\_\_

NAME OF SPOUSE \_\_\_\_\_ OCCUPATION \_\_\_\_\_

SPOUSE EMPLOYED BY \_\_\_\_\_ BUSINESS PHONE \_\_\_\_\_

BUSINESS ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ PHONE # \_\_\_\_\_

**I GUARANTEE PAYMENT IN FULL OF BILLS FOR PATIENT LISTED ABOVE**

**\*\*\*IT IS THE PATIENT'S RESPONSIBILITY TO COMPLETE A NEW INFORMATION SHEET WHEN THERE IS A CHANGE OF INSURANCE COMPANIES OR PERSONAL INFORMATION. PATIENT IS RESPONSIBLE FOR ALL LAB WORK OR X-RAY EXPENSES ORDERED BY DR. RUSH IF INSURANCE FAILS TO COVER THESE EXPENSES.**

SIGNATURE \_\_\_\_\_