Sterling Medical Center, PLLC

PLEASE PRINT

Patient Information

Name_____ Social Security Number _____

Address _____ City _____

State _____ Zip_____ Home Phone (_____)_____ Cell Phone (_____)_____

Sex ☐ Male ☐ Female Date of Birth_____ ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Race _____ Ethnicity _____ Spoken Language ☐ English ☐ Cantonese

May we leave a detailed message at your home? ☐ YES ☐ NO ☐ Mandarin ☐ Other _____

If yes, with whom may we leave a message with? _____

May we contact you through email? ☐ YES ☐ NO

Email Address _____

May we provide medical information to anyone other than you? ☐ YES ☐ NO

If yes, list who _____

In case of emergency who should be notified? _____

Phone (_____)_____ Relationship to patient: _____

Pharmacy:_____ Phone (_____)_____

Pharmacy Crossroads: _____ City: _____

Responsible Party

Relationship to Patient: ☐ Self ☐ Parent ☐ Other _____

Name (if different):_____

Address (if different):_____

City _____ State _____ Zip_____ Phone (_____)_____

Insurance Information

---------- DO YOU HAVE HEALTH INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING ----------

Name of Insurance Company: _____

Subscriber Name: _____ Subscriber Date of Birth:_____

Subscriber SSN: _____ Relationship to Patient:_____

I acknowledge I have received the Notice of Privacy Practices. Initial _____

I consent to physical examination and medical treatment from Sterling Medical Clinic physicians and their ancillary medical personnel as determined to be necessary Initial _____

I authorize that my insurance benefits be paid directly to the physician. I also authorize Sterling Medical Clinic, P.L.L.C. to release any information required to process my claims. If any laps of insurance coverage may occur or if I do not have insurance coverage, I understand I am responsible for all balances on my account. I understand payment is due at the time of service. This consent will end when my current treatment plan is completed.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Printed Name of Patient or Personal Representative Relationship to Patient