North Clinic
~ Where caring is a tradition ~

PATIENT INFORMATION SHEET

☐ **Male** ☐ **Female**
☐ Single ☐ Married
☐ Widowed ☐ Divorced

PATIENT INFORMATION (Please Print)

Name _____ **Date of Birth**_____
(First) (Middle) (Last)
Address _____**Apt.**_____ **Social Security #**_____
City_____**State**_____**Zip**_____**Home Phone**_____
Employer_____ **Work Phone**_____
E-Mail _____ **Cell Phone** _____

Spouse's Name _____**Date of Birth**_____**Social Security#**_____
Employer_____ **Work Phone**_____

BILLING INFORMATION (Complete if patient is under 18 or still covered by guardians insurance)

A)Mother's Name_____**Date of Birth**_____**Social Security#**_____
Home Address_____**City**_____ **State**_____**Zip**_____
Home Phone_____**Employer**_____**Work Phone**_____
B)Father's Name_____**Date of Birth**_____**Social Security#**_____
Home Address_____**City**_____ **State**_____**Zip**_____
Home Phone_____**Employer**_____**Work Phone**_____

EMERGENCY INFORMATION (Someone not living with you – a relative or friend who can be contacted in case of an emergency)

Name_____**Phone#**_____**Relationship to patient**_____

INSURANCE INFORMATION (Name of insurance for the person being seen)

Primary Insurance_____**Policyholder**_____ **Birth Date** _____ **Relationship** _____
Secondary Insurance_____**Policyholder**_____ **Birth Date** _____ **Relationship** _____

Attach Photo copy of Primary Insurance Card	**Attach Photo copy of Secondary Insurance Card**

CLINIC CREDIT INFORMATION: You will receive a monthly statement and we ask that you pay your account in full each month. Your balance will be subject to a finance charge of 1% per month, which is the equivalent of 12% annually. The above information is true and correct and is hereby given to the clinic for the purpose of receiving medical care. As responsible party of the account, I understand the above policies and agree to pay for such treatment under the terms of the clinic as outlined.

ASSIGNMENT OF BENEFITS: I hereby authorize and direct any insurance company to pay the proceeds of any benefits due me for services rendered by NORTH CLINIC directly to the provider. A copy of this can be considered as an original for insurance purposes.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT: I have received the Notice of Privacy Practices.

RELEASE OF INFORMATION: I authorize NORTH CLINIC to release copies, or fax copies, including diagnoses and records of treatment concerning my medical records to insurance companies, referral physicians, hospitals, or dental offices for the purpose of continuing care and/or research purposes.

RELEASE OF TEST RESULTS/CLINIC MESSAGES (Optional): I authorize NORTH CLINIC to release information regarding my test results/clinic messages to _____, Phone #_____ Relationship _____. ☐ Leave messages including test results in my voice mail if I am not available at this telephone number: _____.

SIGNATURE_____ **DATE**_____