Patient Information Sheet

Name: _____

Address: _____

City/State/Zip: _____

DOB: _____

Home Phone #: _____ **Employer:** _____

Cell Phone #: _____ **Work Phone #:** _____

Marital Status: _____

Email Address: _____

Preferred Language: *English:* ☐ *Spanish:* ☐ *Other:* ☐

Which of the following do you consider to be your:

Race:

American Indian/Alaska Native: ☐

Native Hawaiian/Pacific: ☐

Black/African American: ☐

Asian: ☐

White: ☐

Other: ☐

Declined Or No Answer Given: ☐

Ethnicity:

Hispanic/Latino: ☐

Not Hispanic/Latino: ☐

Declined Or No Answer Given: ☐

Emergency Contact: _____

Relationship: _____

Emergency Contact Phone #: _____

Preferred Pharmacy: _____

City: _____ **Pharmacy Phone #:** _____

Referred By: _____

Primary Insurance: _____

Policy ID #: _____ **Group #:** _____

Policy Holder: _____

Policy Holder Address: _____

Policy Holder DOB: _____

Patient's Relationship to Policy Holder: _____

Secondary Insurance: _____

Policy ID #: _____ **Group #:** _____

Policy Holder: _____

Policy Holder Address: _____

Policy Holder DOB: _____

Patient's Relationship to Policy Holder: _____

I verify the demographic information shown on this form is correct. I hereby authorize Margaret A. Smollen M.D., P.C. to release necessary information to my insurance carrier to process all claims and hereby assign to Margaret A. Smollen M.D., P.C. all payments for medical services rendered.

I understand that I am responsible for all amounts not covered by insurance. I further understand that co-pays and co-insurance are due at the time of service.

Signature: _____ Date: _____

319 East Bloomington Street
Iowa City, IA. 52245

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