

BREVARD FAMILY PRACTICE**at Transylvania Regional Hospital
PATIENT INFORMATION SHEET****SECTION ONE: PATIENT'S INFORMATION (IF PATIENT IS A MINOR, INFORMATION IN SECTION FOUR IS REQUIRED)**

SOCIAL SECURITY NUMBER	MR./MRS./MS.	LAST NAME	FIRST NAME	MIDDLE NAME
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MAILING ADDRESS AND PHYSICAL ADDRESS:			DRIVERS LICENSE NUMBER	DATE OF BIRTH
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CITY	STATE	ZIP CODE	HOME PHONE NUMBER	CELL PHONE NUMBER	AGE	SEX (M/F)
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MARITAL STATUS: M = Married W = Widowed S = Single D = Divorced X = Separated**EMPLOYMENT:** 01 = Full Time 02 = Part Time 03 = None 04 = Self-Employed 05 = Retired**STUDENT:** P = Part Time F = Full Time N = None**RELATION TO INSURED:** 01 = Self 02 = Spouse 03 = Child 09 = Other**SECTION TWO: PATIENT'S EMPLOYER**

EMPLOYER	OCCUPATION
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EMPLOYER'S MAILING ADDRESS			ZIP CODE
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CITY	STATE	TELEPHONE NUMBER
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SECTION THREE: PATIENT'S SPOUSE

SPOUSE	DATE OF BIRTH	TELEPHONE NUMBER
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MAILING ADDRESS		
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CITY	STATE	ZIP CODE
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EMPLOYER	TELEPHONE NUMBER
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EMERGENCY CONTACT (NOT LIVING WITH YOU)**TELEPHONE NUMBER****SECTION FOUR: PERSON(S) RESPONSIBLE FOR MEDICAL CARE (IF OTHER THAN PATIENT)**

1. NAME	HOME TELEPHONE NUMBER
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MAILING ADDRESS	WORK TELEPHONE NUMBER
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CITY	STATE	ZIP CODE
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Insured Policy Holder SS #	Insured Policy Holder DOB	***CURRENT PHARMACY***
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2. NAME	HOME TELEPHONE NUMBER
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MAILING ADDRESS	WORK TELEPHONE NUMBER
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CITY	STATE	ZIP CODE
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SECTION FIVE: INSURANCE INFORMATION**CHECK HERE IF YOU DO NOT HAVE INSURANCE**

PRIMARY INSURANCE	SECONDARY INSURANCE
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Please present your insurance cards upon arrival. Payment is expected at the time of service unless prior arrangements are made.

I authorize the release of any medical or other information necessary to process insurance claims. _____ Signed	I authorize payment of medical benefits directly to this practice for the services rendered. _____ Signed
_____ Date	_____ Date