Trailside Health
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HELPFUL INFORMATION FORM

Welcome! Thank you for choosing our group. In order to serve you properly, we would like the following information. Please answer what you can. All information is confidential.

Patient Name_____ Date_____
FIRST MI LAST
Birthdate_____ Female___ Male___ SS#_____(you may decline)
Address_____ Home Telephone#_____
City_____ State_____ ZIP_____ Work Telephone #_____
Please circle your situation: Minor Single Married Widowed Divorced Separated
Occupation_____ Employer_____
Spouse's Name_____ Spouse's Employer_____
Spouse's Work Phone_____ If patient is a student, name of school/college, city, state:
_____
Person to contact in case of emergency_____ Phone#_____
Address_____
Relationship_____ Pharmacy_____

THE INEVITABLE INSURANCE INFORMATION... but insurance is not necessary.
Circle here if SELF , then skip to the "Primary Insurance Co." in this section
Name of insured_____ Relationship to patient_____
SS# of insured_____ (not required, but insurance won't pay without it)
Name of insured's employer_____
Address of Employer_____

Primary INSURANCE Co:_____
Card#_____ Group#_____
What is your co-payment amount ? _____ Effective Date _____
Do you have ADDITIONAL INSURANCE ? YES_____ NO_____
If 'YES', please complete the following:
Secondary INSURANCE Co: _____
Card#_____ Group#_____
What is your co-payment amount ? _____ Effective Date _____
Name of insured_____ Relationship to patient_____
SS# of insured_____ (not required, but insurance won't pay without it)
Name of insured's employer_____
Address of Employer_____

Authorization, release, & responsibility statement...
I authorize the release of information and payments and am responsible for supporting this community service as outlined in the Consent to Care agreement.

Signature of patient or parent of patient_____ Date_____