Linda Sewell MD, PC

Patient Name: _____ **Social Security #**: _____-_____-_____ **DOB**: _____

Ethnicity (circle one): Hispanic/Latino Non-Hispanic/Latino **Email Address:** _____

Marital Status (circle one): Single Married Divorced Separated Domestic Partner Widowed

Race (circle one): African American American Indian/Alaska Native Asian White Native Hawaiian/Pacific Islander

Mailing Address: _____ _____ _____ _____
Street City State Zip

Home Phone: ( ) _____ **Cell Phone**: ( ) _____ **Work Phone**: ( ) _____

Employer: _____ **Occupation**: _____

Employer Address: _____ _____ _____ _____
City State Zip

Spouse: _____ **Social Security #**: _____-_____-_____ **DOB**: _____

ANY RESTRICTIONS: ☐ **NONE** ☐ **MESSAGE ONLY** **Spouse Cell**: ( ) _____

Spouse Employer: _____ **Spouse Work Phone**: ( ) _____

If someone other than the PATIENT is responsible for payment, complete the following: ANY RESTRICTIONS: ☐ **NONE** ☐ **MESSAGE ONLY**

Name of Responsible Party: _____ **Social Security #**: _____-___-_____ **DOB**: _____

Address: _____ **Relationship to Patient**: _____

Cell Phone: ( ) _____ **Work Phone**: ( ) _____

Employer: _____ **Address**: _____

CONTACTS/IN CASE OF EMERGENCY: ☐ **PATIENT DECLINES CONTACTS**

Relative to contact (other than spouse): _____ **Phone**: ( ) _____

ANY RESTRICTIONS: ☐ **NONE** ☐ **MESSAGE ONLY** **Relationship to Patient**: _____

Other person to contact: _____ **Phone**: ( ) _____

ANY RESTRICTIONS: ☐ **NONE** ☐ **MESSAGE ONLY** **Relationship to Patient**: _____

How do you intend to pay? (Circle one) Cash Check Credit Card Insurance Medicare OHP

Primary Insurance: _____ Address: _____
Phone #: _____ Name of Insured: _____ Relationship: _____
Policy #: _____ Group #: _____ DOB: _____

Secondary Insurance: _____ Address: _____
Phone #: _____ Name of Insured: _____ Relationship: _____
Policy #: _____ Group #: _____ DOB: _____

I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to release information necessary to secure payment. No show and collection fees are explained in the welcome letter.

I also authorize Linda Sewell, MD to render treatment for the above named patient and all insurance payments be made to the provider for services rendered. I further permit the medical provider to release information to the Social Security Administration and other medical providers that may coordinate treatment for the above named patient.

Signature: _____ **Date**: _____