St. Clair Specialty Physicians
ADVANCED MEDICINE • COMPASSIONATE CARE

Name:		
Home Address:		
City:	**State:**	**Zip:**
Home Phone:	**Cell Phone**:	
Date of Birth:	**SSN:**	
Sex:	**Marital Status:**	
Email:	**Primary Language:**	

Race: ***Please check box:***

☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Black/African American
☐ American Indian/Alaska Native ☐ White ☐ More than 1 race ☐ Unreported / Refused to report

Ethnicity: ***Please check box:***

☐ Hispanic / Latino ☐ Not Hispanic / Latino ☐ Unreported / Refused to report

In the event of an emergency please contact:		
Name:		
Home Ph.:	Work Ph.:	Cell Ph.:

Physician Information:

Primary Care Physician: Phone:
Address:
Referring Physician: Phone:
Address:

Pharmacy Name:
Address: Phone:

Mail Order Pharmacy Name:
Address: Phone:

Insurance Information:

Primary Ins:	Secondary Ins:
Subscriber:	Subscriber:
DOB:	DOB:
Policy ID:	Policy ID:
Group #:	Group #:
Employer:	Employer:

Assignment of Benefits / Authorization for Treatment:
I hereby authorize treatment and authorize the provider of medical services to release information for these services to my insurance carrier for payment. I further authorize that benefits be made payable to the provider on my behalf. I understand that I am financially responsible for the charges not covered by my insurance carrier.

_____ _____
Patient / Authorized Representative Signature **Date**