Mark H. Cripe, D.O.
Christine M. Habib, M.D.
Caitlyn Truong, M.D.
Patient Information Sheet

Patient Name _____ E-mail Address _____

Patient Address _____ City_____ State _____ Zip _____

Home Phone _____ Date of Birth_____ Age _____

Cell Phone _____ Sex: ❑ Male ❑ Female

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced Social Security # _____

Employer _____ Employer's Address _____

Work Phone _____ Occupation _____

Name of Spouse or Responsible Parent _____ Date of Birth _____

Occupation _____

Employer _____ Employer's Address _____

Work Phone _____ Social Security # _____

Emergency Contact _____ Relation _____ Phone _____

Primary Insurance Co. _____ Insured Name _____

Social Security # _____ Policy # _____

Secondary Insurance Co. _____ Insured Name _____

Social Security # _____ Policy # _____

Referring Physician _____ Family Doctor _____

Pharmacy Name _____ Pharmacy Phone _____

Due to new HIPPA Privacy Rules, please designate below person(s) you authorize to communicate information regarding your care.

Name _____ Relationship _____ Phone _____

Do you authorize medical and scheduling information to be left on your answering machine, voicemail and with family member? ❑ Yes ❑ No

CONSENT FOR RELEASE OF INFORMATION AND PAYMENT OF BENEFITS

I, hereby, authorize the release of any information acquired in the course of examination or treatment needed for any third party claims.

I, hereby, authorize payment of medical benefits by any third party insurance coverage to be made to Mark H. Cripe, D.O. / Christine M. Habib, M.D. / Caitlyn Truong, M.D. I understand that I am and I remain financially responsible for these changes.

_____ _____ _____

Signature of Patient or Parent if Patient is a Minor Date Time