MEA Medical Clinics

**Patient Information Sheet**

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**Patient Information**

Name _____ Social Security # _____Sex: M F Other
Last First Middle

Date of Birth _____ other known name(s) _____

Mailing Address _____ _____ _____ _____
City State Zip

Preferred contact number _____ Mother's Maiden Name _____ ___

Would you like to receive SMS text messages for appointment reminders? Yes/No

Email address _____ Language |_ English |_ Spanish |_ Other _____

**Marital Status:** (circle one)

Married
Legally Separated
Widowed
Unknown
Divorced
Single
Significant Other
Other

**Ethnicity:** (circle one)

Hispanic or Latino
Not Hispanic or Latino
Unknown
No Answer

**Race:** (circle one)

American Indian or Alaska Native
Asian
Black or African American
Native Hawaiian or Other Pacific Islander
White or Caucasian

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**Guarantor Information (If different from patient)**

Name _____ Social Security # _____Sex: M F Other
Last First Middle

Date of Birth _____ other known name(s) _____

Mailing Address _____ _____ _____ _____
City State Zip

Relationship to patient _____Preferred contact number _____

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Employer if applicable (Responsible party if patient is a child) _____

Employment Status: (circle one) disabled full time part time not employed on active military duty retired
Self-employed student full-time student part-time unknown

Please indicate any special needs you may have. _____

Primary Care Provider _____

Do you have an Advanced Directive? Yes/No (circle one)

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**Insurance Information (Please circle)**

None| Self| Commercial| Medicare| Medicaid- if insured please present card to clinic representative

**(Primary Coverage)**

Insurance Company _____

Member ID # _____

Subscriber Name _____

Relationship to Patient _____

Effective Date _____Group #_____

Group # _____

Covered Through: (circle one) Current employer Retirement
Cobra/continuation of benefits
Other _____

**(Secondary/Supplemental Coverage)**

Insurance Company _____

Member ID# _____

Subscriber Name _____

Relationship to Patient _____

Effective Date _____Group # _____

Group # _____

Covered Through: (circle one) Current employer Retirement
Cobra/continuation of benefits
Other _____

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Emergency Contact Name _____ Emergency Contact Phone Number_____

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**Personal Representation Designation**

Per the Health Insurance Portability and Accountability Act of 1996 you have the right to have one or more-person(s) act as your representative to make decisions about the uses and sharing of health information. Should you need to change your Designee at any point, please notify a clinic representative.

Designee(s) Name _____Relationship to patient_____

Mailing address _____Phone Number _____

**Information permissions (Please circle)** Financial and Demographic information |Healthcare Information |All Information

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**Is this visit related to an injury:** YES NO **Date of injury:** _____ **Type:** Auto Work Other _____

**Method of payment:** CASH CHECK CREDIT CARD

**By Signing below, I certify that all information is true and correct to the best of my knowledge:**

Print Name of Patient/Parent/Guardian: _____

Signature of Patient/Parent/Guardian: _____

Date: _____Time _____