PETERSON
Community Care

Patient Information Sheet

Patient Name (Last, First, MI):	Gender: M F	Date of Birth(MM/DD/YY):	Social Security Number:
Mailing Address:		Home Phone (Primary Y/N):	Work Phone:
City: State: Zip:		Cell Ph#/Pager (Primary Y/N):	Marital Status:
Ethnicity/Race:		Maiden Name:	Driver's License #:
Preferred Local Pharmacy: Preferred Mail-In Pharmacy:		How did you hear about us?	
Employment Status:(Circle one) Employed Full Time Student Part time Student Retired		Occupation:	
Patient's Employer:		Employer's Address:	
Emergency Contact w/Phone and Relationship to Contact:		Patient Email Address:	
Spouse's Name:		Spouse's SSN:	Spouse's DOB:
Spouse's Employer & Telephone Number:		Other Household Members:	
Responsible Party (Fill out only if other than patient.)			
Name:		Relationship to Patient:	
Address:		Employer & Telephone Number:	
Home Phone:	Cell Phone:	Social Security Number:	Date of Birth:
Health Insurance Information			
Primary Insurance Health Care Plan:		Secondary Insurance Health Care Plan:	
ID#	Group #	ID#	Group #
Name of Policy Holder (Last, First, MI):		Name of Policy Holder (Last, First, MI):	
Policy Holder's Address:		Policy Holder's Address:	
Telephone Number:	Date of Birth:	Telephone Number:	Date of Birth:
Social Security Number:	Relationship to Patient:	Social Security Number:	Relationship to Patient:

AFTER CLINIC HOURS (4:45PM TO 7:00AM) AND WEEKENDS: You many reach the ON-CALL PCC Provider by calling our office at 830-258-7900 and following the instruction as given.

All services rendered are the financial responsibility of the patient. The patient is responsible for payment regardless of insurance coverage. Billing information will be provided to expedite patient reimbursement from private insurance carriers.

I hereby authorize the provider of services to release information concerning my examination and/or treatment for insurance purposes and to receive direct payment for benefits payable to me for services rendered. I also authorize release of medical information for the purpose of further evaluation of treatment.

Signature _____ Date _____