SKY INTEGRATIVE MEDICAL CENTER
408 FONTAINE PLACE SUTIE 101
RIDGELAND, MS 39157
601-617-7717 • 601-510-9194

DATE:________________________

PATIENT NAME:________________________

DATE OF BIRTH:________________________AGE:__________ SOCIAL SECURITY #:________________________

GENDER: ☐ MALE ☐ FEMALE **MARITAL STATUS:** ☐ SINGLE ☐ MARRIED ☐ WIDOW ☐ DIVORCED ☐ SEPARATED

PHONE #:________________________ SECONDARY PHONE #:________________________

STREET ADDRESS:________________________

CITY:________________________ STATE:________________________ ZIP CODE:________________________

E-MAIL:________________________ OCCUPATION:________________________

EMPLOYER:________________________ EMPLOYER PHONE:________________________

EMERGENCY CONTACT:________________________ RELATIONSHIP:________________________

EMERGENCY CONTACT NUMBER:________________________

WHOM MAY WE THANK FOR REFERRING YOU TO US?:________________________

INSURANCE COMPANY:________________________

SUBSCRIBER ID:________________________ GROUP:________________________

IF OTHER THAN THE PATIENT, PLEASE TELL US ABOUT THE POLICY HOLDER

POLICY HOLDER'S NAME:________________________ POLICY HOLDER'S DATE OF BIRTH:________________________

POLICY HOLDER'S PHONE #:________________________RELATIONSHIP TO PATIENT:________________________

POLICY HOLDER'S EMPLOYER:________________________EMPLOYER PHONE #:________________________

STREET ADDRESS OF POLICY HOLDER:________________________

CITY:________________________ STATE:________________________ ZIP CODE:________________________

REASON FOR VISIT:________________________

PLEASE LIST ANY ALLERGIES TO MEDICATION, X-RAY DYES OR FOOD:________________________

____

I/WE UNDERSTAND THAT I/WE ARE FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I/WE AGREE TO ACCEPT TOTAL RESPONSIBILTY FOR ALL DAMAGES AND AGREE TO PAY AT THE TIME SERVICES ARE RENDERED, OR NOT LATER THAN 30 DAYS OF SUCH SERVICES. IN THE EVENT OF DEFAULT, I/WE AGREE TO PAY ALL COST OF COLLECTION, INCLUDING ATTORNEY FEES.

X____

I HEREBY AUTHORIZE RELEASE OF MEDICAL INFORMATION NECESSARY FOR THE PREPARATION OF INSURANCE CLAIMS ON MYSELF, AND AUTHORIZE THE INSURANCE TO MAKE PAYMENT DIRECT TO THE PHYSICIAN ON ANY UNPAID CLAIM. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURACNE CLAIMS, INCLUDING ELECTRONIC SUBMISSIONS.

X____