PREMIER SUBURBAN
MEDICAL GROUP

Patient Data Information

Name _____ Birth Date ____ / ____ / ____ Sex: Male Female

Phone_____ Cellular Phone _____ Email _____

Ok to leave a message? Yes ☐ No ☐

Address_____ City _____ State _____ Zip _____

SS# _____ Marital Status: Single Married Widowed Divorced

Race: _____ Ethnicity: _____ Referred by _____

Pharmacy (name, location, phone#) _____

Mail Order Pharmacy (if applicable)_____

Emergency Contact: _____ Relationship _____ Phone _____

Preferred Method of Communication (Choose One) : Phone Text

Patient Instructions for Communication Preferences:

I authorize Silver Cross Medical Group to contact for results:

Myself Only ☐
_____ Home
_____ Cell
Ok to leave a message on answering machine? _____ Yes _____ No

Other ☐ Name _____ Relationship _____

Other ☐ Name _____ Relationship _____

Did you sustain an injury at work? _____ Are your injuries accident related? _____

Authorization to Treat:

I hereby authorize my insurance benefits to pay directly to Silver Cross Medical Group, realizing I am responsible to pay non-covered services. I authorize the release of medical information to insurance carrier

Signature: _____ Date _____