STEPHANIE TAYLOR, M.D., Ph.D
PATIENT INFORMATION SHEET

Patient Name:_____ **Date:**_____
First M.I. Last

Mailing Address:_____ **City:**_____ **State:**___ **Zip Code:**_____

Street Address (if different from mailing):_____

Home Phone:_____ **Cell Phone:**_____ **Work Phone:**_____

Date of Birth:_____ **Social Security #**_____ **Marital Status:**_____

Email Address:_____

Employer:_____
Name Address City, State, Zip Code

Primary Care Physician:_____
Name Address City, State, Zip Code

Emergency Contact:_____
Name Home Phone Cell Phone

What Pharmacy do you use?:_____
Name Address City

HOW DID YOU HEAR ABOUT US?_____

INSURANCE INFORMATION

PLEASE COMPLETE THE FOLLOWING INFORMATION BELOW AND PRESENT YOUR INSURANCE CARD(S) TO THE RECEPTIONIST (TO BE ATTACHED TO YOUR LAB ORDER)

SELF-PAY: (circle one) *Non Provider No Insurance*

Primary Insurance:_____ **Insured's Name:**_____ **DOB:**_____

Relationship to Insured (please circle one): *Self Spouse Child Other* **Insured's SSN#:**_____

Insured's Employer:_____
Name Address City, State, Zip Code

Physician charges will be due at time of service. We will courtesy bill your insurance company. You are responsible to contact your insurance prior to services to determine if services provided are covered.

I consent to treatment for the care of the above patient. I authorize the release of all medical records to the referring and family physicians and to insurance carriers as needed to process a claim. I allow fax transmittal of medical records if necessary. I understand that I am financially responsible for all charges.

Patients Signature:_____ **Print Name:**_____