sunRise MEDICAL GROUP

••• stay well, shine on •••

Patient Information

_____

Patient Name and DOB (PRINT)

_____

Street Address, City and State and Zip

_____

Email Address (Access to Patient Portal)

_____ _____ _____

Home Phone **Work Phone** **Cell Phone**

Social Security #: _____

Preferred Method of Contact (circle one): Home Work Cell

Gender: O Male O Female

Marital Status: O Divorced O Domestic Partner O Single

O Legally Separated O Married O Widowed

Voluntarily, self-identified race:

O White O Asian O Other
O Black/African American
O Native Hawaiian/Pacific Islander

Voluntarily, self-identified ethnicity:

O Spanish/Hispanic Origin
O Not of Spanish/Hispanic Origin
O Unknown

Language Preference: O English O Spanish O French O Other_____

If under 18: Mother's Maiden Name_____
Responsible Party_____
Address_____
Phone_____

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Do You Have a Hearing Impairment? O Yes O No details:_____

Do You Have a Vision Impairment? O Yes O No details:_____

Insurance Information:

Insurance Company:_____

Policy #:_____ Group #:_____

Subscriber Name:_____ Subscriber DOB:____/____/____

Subscriber Social Security #: _____

Relationship to Subscriber (if other than self) : _____

Emergency Contact: _____ Relationship:_____

Phone #: _____

Pharmacy Information:

Pharmacy Name: _____

Address: _____

Phone #: _____

******PLEASE BRING INSURANCE CARD TO EVERY APPOINTMENT**

******PLEASE NOTIFY US OF ANY INSURANCE CHANGES UPON ARRIVAL**

******BEFORE YOUR APPOINTMENT PLEASE CHANGE YOUR PRIMARY CARE PROVIDER WITH YOUR INSURANCE COMPANY IF NECESSARY**

******PLEASE BRING MEDICATION LIST**