PATIENT INFORMATION SHEET R. CRAIG MCKEE, M.D., LLC

FIRST NAME____________________________ M.I.______ LAST___________________________AGE_____BIRTHDATE___________

ADDRESS ____

CITY____ STATE______ ZIP_______________

PATIENT SSN#_____________________________HOME PHONE_______________________CELL PHONE______________________

EMPLOYER NAME ____ WORK PHONE_____________________

EMPLOYER ADDRESS ____

MAY WE LEAVE A MESSAGE ON YOUR PHONE? PLEASE CIRCLE ONE. CELL PHONE? (YES / NO) HOME PHONE? (YES / NO)

IF PATIENT IS MINOR, PARENT NAME______________________________BIRTHDATE ___________ SSN#______________________

SPOUSE (OR OTHER PARENT) NAME________________________________BIRTHDATE ___________ SSN#______________________

SPOUSE (OR OTHER PARENT) EMPLOYER____ WORK PHONE _____________________

NAME OF EMERGENCY CONTACT (NOT LIVING IN SAME HOME) ____

RELATIONSHIP___________________________________PHONE_________________________

PRIMARY INSURANCE

POLICY HOLDER'S NAME____BIRTHDATE___________

NAME OF INSURANCE CO.____ ID# __________________

ADDRESS TO SEND CLAIMS____

SECONDARY INSURANCE

POLICY HOLDER'S NAME____BIRTHDATE___________

NAME OF INSURANCE CO.____ ID# __________________

ADDRESS TO SEND CLAIMS____

FAMILY DOCTOR ________________________________ FILED WORKERS' COMPENSATION? YES_____ NO_____

REFERRERING DOCTOR___________________________ AUTO ACCIDENT? YES______NO_____

DATE OF INJURY/TIME___________________________ (A.M.) (P.M.)

HOSPITAL NAME ________________________________

ATTORNEY'S NAME/ADDRESS (if applicable) ____

CONSENT AND AUTHORIZATION

The undersigned hereby authorizes R. Craig McKee, M.D., LLC to examine, photograph and provide medical care and to release any medical information and/or photographs necessary to process my insurance claim for services provided by R. Craig McKee, M.D., LLC. I authorize my insurance company benefits be paid directly to R. Craig McKee, M.D., LLC and fully understand that I am directly responsible for all medical bills and if necessary reasonable attorney fees and other costs incurred to collect said professional fees due R. Craig McKee, M.D., LLC for medical services rendered me or my dependents.

SIGNATURE____DATE_______________

WITNESS ____ DATE_______________