Medical Arts Unlimited, Corp. & APEX Sinus Center Patient Information Sheet

First name: ___________________________ Middle initial: _________ Last name: ___________________________ Sex: ☐M ☐F

Date of Birth: _________________________ Primary Care Physician: ____
NAME CITY

Home Address: ____
ADDRESS CITY STATE ZIP

Home phone: _________________________ Cell phone: __________________________ Work: ______________________________

E-mail address: ____

Preferred method of communication: ☐ Home number ☐ Cell number ☐ Email ☐ Other: ______________________

Marital Status: ☐Single ☐Married ☐Other: _____________ Employment Status: ☐FT ☐PT ☐Retired ☐Other ☐N/A

Responsible Party/Name of Insured ____ Date of Birth_______________

Emergency contact: ____ Relationship: __________________
NAME PHONE NUMBER

Do we have permission to contact this person regarding matters concerning your care? ☐ Yes ☐ No

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Ethnicity (check one):

- ☐ Non-Hispanic
- ☐ Hispanic
- ☐ Refused to Report

Primary race (check one):

☐ White ☐ Asian ☐ Other Pacific Islander ☐ Hispanic
☐ Native American ☐ Other Race
☐ African American/Black ☐ Native Hawaiian ☐ Unreported/Refused

Preferred Language (check one): ☐ English ☐ Spanish ☐ Other: ______________ Interpreter Needed? ☐Yes ☐No

Do you have an advanced directive such as a living will or medical power of attorney? ☐ Yes ☐ No
Is your visit with us today due to an automobile accident or work place accident? ☐ Yes ☐ No

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Preferred Pharmacy #1: ____ Mail Order? ☐ Yes ☐ No
NAME CITY
Preferred Pharmacy #2: ____ Mail Order? ☐ Yes ☐ No
NAME CITY

ELECTRONIC PRESCRIPTIONS: *Our electronic medical record program accesses your prescription/medication history in order for us to safely prescribe your medication. By signing this, you authorize us to do so.*

PAYMENT POLICY: *Our policy requires that all payments are made at the time of service by patients who do not have health insurance coverage; or whose insurance will not cover a particular service, such as cosmetic procedures. In instances where insurance is provided, as a courtesy to you, we will bill your insurance. It is to be understood that you are responsible for charges incurred during your visit. Therefore, in the event that your insurance carrier does not pay the bill for any reason, the entire balance will be your responsibility, and must be paid in full. If the provider is a participating provider in your health plan, you are responsible for co-pay/ co-insurance or any unmet portion of your deductible. By signing this, you acknowledge that you understand the above payment policy and agree to abide by it. Moreover, you agree to authorize your insurance carrier to pay any medical benefits directly to Medical Arts Unlimited, Corp.*

Signature: ____ *Date:* ________________________
PATIENT/GUARDIAN RELATIONSHIP TO PATIENT