Sally L. Harris MD

Patient Information Sheet

Today's Date_____

PLEASE PRESENT YOUR INSURANCE CARD and ID to THE FRONT DESK

Patient Name:_____ Social Security #:_____
Patient Address:_____ Home Phone #:_____
City/State/Zip:_____ Cell Phone #:_____
Patient Gender:_____ e-mail address:_____
Date of Birth:_____

RESPONSIBLE PARTY INFORMATION IF OTHER THAN PATIENT

Name:_____ Cell Phone #:_____
Relationship to Patient:_____ Home Phone #:_____
Address:_____
City/State/Zip:_____

Primary Care Physician:_____ Emergency Contact:_____
Phone:_____ Relationship to Patient:_____
Referred By:_____ Phone:_____
Phone:_____

I understand that the clinic has a no show fee of $25.00 which I will pay if I do not cancel my appointment within 24 hours.

Patient (Authorized Person) Signature:_____

I hereby authorize all medical benefits to which I am entitled to Sandia Neurology PC. I understand that I am financially responsible for all charges, whether or not paid by said insurance company. I hereby authorize said assignees to release any information to determine these benefits for related services.

Patient (Authorized Person) Signature:_____