

# Sterling Medical Center, PLLC

PLEASE PRINT

## Patient Information

Name \_\_\_\_\_ Social Security Number \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone (\_\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_\_) \_\_\_\_\_  
Sex  Male  Female Date of Birth \_\_\_\_\_  Single  Married  Divorced  Widowed  Separated  
Race \_\_\_\_\_ Ethnicity \_\_\_\_\_ Spoken Language  English  Cantonese  
May we leave a detailed message at your home?  YES  NO  Mandarin  Other \_\_\_\_\_  
If yes, with whom may we leave a message with? \_\_\_\_\_  
May we contact you through email?  YES  NO  
Email Address \_\_\_\_\_  
May we provide medical information to anyone other than you?  YES  NO  
If yes, list who \_\_\_\_\_  
In case of emergency who should be notified? \_\_\_\_\_  
Phone (\_\_\_\_\_) \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
Pharmacy: \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_  
Pharmacy Crossroads: \_\_\_\_\_ City: \_\_\_\_\_

## Responsible Party

Relationship to Patient:  Self  Parent  Other \_\_\_\_\_

Name (if different): \_\_\_\_\_

Address (if different): \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

## Insurance Information

----- DO YOU HAVE HEALTH INSURANCE?  Yes  No IF YES, COMPLETE THE FOLLOWING -----

Name of Insurance Company: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Subscriber Date of Birth: \_\_\_\_\_

Subscriber SSN: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

I acknowledge I have received the Notice of Privacy Practices.

Initial \_\_\_\_\_

I consent to physical examination and medical treatment from Sterling Medical Clinic physicians and their ancillary medical personnel as determined to be necessary

Initial \_\_\_\_\_

I authorize that my insurance benefits be paid directly to the physician. I also authorize Sterling Medical Clinic, P.L.L.C. to release any information required to process my claims. If any laps of insurance coverage may occur or if I do not have insurance coverage, I understand I am responsible for all balances on my account. I understand payment is due at the time of service. This consent will end when my current treatment plan is completed.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient or Personal Representative

\_\_\_\_\_  
Relationship to Patient