

**Sunflower Medical Group  
PATIENT INFORMATION**

<b>Name:</b>	<b>Date of Birth:</b>
<b>Address One:</b>	<b>Social Security #:</b>
<b>City:</b>	<b>Sex:</b>
<b>State:</b> <b>Zip:</b>	<b>Primary Phys:</b>
<b>E-Mail Address:</b>	<b>Employer:</b>
<b>Home Phone#:</b>	<b>Emergency Contact:</b>
<b>Work Phone#:</b>	<b>Emergency Phone#:</b>
<b>Cell Phone#:</b>	<b>Emergency Relationship:</b>
<b>Race:</b> Circle One: Hispanic/Non-Hispanic	<b>Language:</b>

**FINANCIAL RESPONSIBILITY**

<b>Name:</b>	<b>Date of Birth:</b>
<b>Address One:</b>	<b>Social Security#:</b>
<b>City:</b>	<b>Employer:</b>
<b>State:</b> <b>Zip:</b>	<b>Employer Address:</b>
<b>Home Phone#:</b>	<b>Employer City:</b>
<b>Work Phone#:</b>	<b>Employer State:</b>
<b>Cell Phone#:</b>	

**INSURANCE INFORMATION**

<b>Primary Insurance:</b>	<b>Secondary Insurance:</b>
<b>Certificate#:</b>	<b>Certificate#:</b>
<b>Group Number:</b>	<b>Group Number:</b>
<b>Policy Holder:</b>	<b>Policy Holder:</b>
<b>DOB:</b>	<b>DOB:</b>

**Authorization to Pay Benefits to Physicians:** I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself of my Provider, Sunflower Medical Group when they accept assignment.

**Authorization to Release Medical Information:** I hereby authorize Sunflower Medical Group to release any information necessary for my course of treatment.

**Acknowledgement of Privacy Notice:** I acknowledge that Sunflower Medical Group's Privacy Notice, effective November 10, 2013 was made available to me.

\_\_\_ Yes \_\_\_ No      Our office can leave messages to return our call on  
   \_\_\_ home answering machine and/or \_\_\_ office voice mail

**I hereby authorize the following individuals to access my medical information**

<b>Name</b> _____	<b>Phone Number</b> _____
<b>Name</b> _____	<b>Phone Number</b> _____

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date