2022 Sunflower Medical Group PATIENT INFORMATION

TAILENLE	NIOMMATION
Name:	Date of Birth:
Address One:	Social Security #:
City:	Sex:
State: Zip:	Primary Phys:
E-Mail Address:	Employer:
Home Phone#:	Emergency Contact:
Work Phone#:	Emergency Phone#:
Cell Phone#:	Emergency Relationship:
Race:	Language:
Circle One: Hispanic/Non-Hispanic	
FINANCIAL RE	SPONSIBILITY
Name:	Date of Birth:
Address One	Social Security#:
City:	Employer:
State: Zip:	Employer Address:
Home Phone#:	Employer City:
Work Phone#:	Employer State:
Cell Phone#:	
INSURANCE IN	VFORMATION
Primary Insurance:	Secondary Insurance:
Certificate#:	Certificate#:
Group Number:	Group Number:
Policy Holder:	Policy Holder:
DOB:	DOB:
Authorization to Pay Benefits to Physicians: I authorization to process health insurance claims. I also request payment of Group when they accept assignment. Authorization to Release Medical Information: I he information necessary for my course of treatment.	of benefits to myself of my Provider, Sunflower Medical
Acknowledgement of Privacy Notice: I acknowledge effective November 10, 2013 was made available to me.	that Sunflower Medical Group's Privacy Notice,
YesNo Our office can leave messages to returnhome answering machine,offi	
I hereby authorize the following individuals to acce	ess my medical information
Name	Phone NumberPhone Number
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Signature	Date