

Today's Date: _____

Olentangy Private Internal Medicine

Patient Information

Title: _____ First Name: _____ Middle Name: _____

Last Name: _____ Maiden Name: _____

(Name patient goes by): _____ Marital Status: _____ Gender: _____

Date of Birth: _____ Social Security Number: _____ - _____ - _____

Address: _____

City: _____ State: _____ Zip/Postal Code: _____

Driver's License Number: _____ State: _____

Home Phone Number: (____) _____

Work Phone Number: (____) _____

Cell Phone Number: (____) _____

Email Address: _____

Preferred Method of Communication: _____

Emergency Contact Name: _____ Relationship: _____

Contact Number: (____) _____ Type: cell/home/work

**Please provide our office with your current insurance card
and picture ID for your files.**

I authorize Olentangy Private Internal Medicine to furnish professional services to me or my dependent as is necessary in the prevention, diagnosis or treatment of any illness or injury. I request and authorize that any medical benefits due me for any services rendered to me by Olentangy Private Internal Medicine to be paid to Olentangy Private Internal Medicine as assigned benefits. I authorize Olentangy Private Internal Medicine to release any of my or my dependent's medical information as necessary in the filing of any insurance claim. I also authorize a copy of this signed statement to be used by Olentangy Private Internal Medicine in place of the original to request payment of medical insurance.

Signed: _____ Date: _____