SMC
SARASOTA MEDICAL CENTER

Patient Information - Please Print

Today's Date:_____ Email Address:_____

Patient's Name:_____
(LAST) (FIRST) (MIDDLE INTIAL)

Local Address:_____

City:_____ State:_____ Zip Code:_____

Billing Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone: ( )_____ Pref Y / N Cell Phone: ( )_____Pref Y / N

Age:____ Date of Birth: ____/ ____/ ____ Sex □ M □ F Social Security #:_____

Marital Status: □ Single □ Married □ Divorced □ Separated □ Widowed □ Minor

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Unknown □ Declined to Specify

Race: □ American Indian/Alaskan Native □ Asian □ Black or African American

□ Native Hawaiian or Other Pacific Islander □ White □ Other Race □ Declined to Specify

If Minor, Responsible Parties:_____

If different address than above:_____

City:_____ State:_____ Zip Code:_____

Primary Insurance Carrier:_____ Policy #:_____

Secondary Insurance Carrier:_____ Policy #:_____

Insurance Policy Holder:_____ Date of Birth:_____/ _____/ _____

Employer:_____ Occupation:_____

How did you hear of SMC? □ Internet □ Family/Friend □ Print Media □ Other _____

If Auto Accident Case:

Auto Insurance Carrier:_____ Phone:_____

Claim #: _____ Policy #: _____

Adjuster's Name: _____ Date of Accident: _____

Attorney: _____ Attorney Phone: _____

Contact/ Case Manager: _____

If Worker's Compensation Case:

Employer: _____ Date of Injury: _____

Work Comp Insurance Company: _____ Case Manager: _____

Claims Mailing Address: _____

Claim #: _____ Phone #: _____