Silver Sage Center for Family Medicine
Andrew Pasternak, M. D.
Teresa Angermann, D. O.

PATIENT INFORMATION SHEET

Patient Name_____
Last First MI **Date of Birth**

Physical Address_____
Zip Code

Mailing Address_____
Zip Code

Patient Phone _____ Cell _____ Work _____

Social Security #_____ Sex: M F Marital Status: S M D W

If Minor, Parent Name: _____

Emergency Contact: _____
Name Phone Relationship

Employment Information

Employer: _____

Employer Address: _____

Spouse/Parent: _____ Occupation: _____

Employer: _____ Work Phone: _____

Insurance Information

Name of Subscriber: _____ Relationship to Pt. _____

Birthdate of Subscriber: _____ Social Security # _____

Name of Employer: _____ Work Phone: _____

Insurance Co.: _____

Policy #: _____ Group #: _____

I understand that co-payments are due at time of visit. I authorize payment of medical benefits from my insurance company to Silver Sage Center for Family Medicine. I also authorize the release of any medical information necessary to process any medical claim. I realize that I am responsible for any balance my insurance company does not cover/pay. I acknowledge receipt of the privacy policies and practices notice.

Signature: _____ Date: _____