

**THE MEDICAL GROUP INC**  
Patient History Information

Date \_\_\_\_\_

Patient Name \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status \_\_\_\_\_

Date of Birth \_\_\_\_\_ Place of Birth \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_

Patient employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone (\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_

Social Security Number \_\_\_\_\_ Driver's License No. \_\_\_\_\_ State \_\_\_\_\_

Name of Spouse \_\_\_\_\_ Date of Birth \_\_\_\_\_

Spouse Social Security Number \_\_\_\_\_ Business Phone (\_\_\_\_) \_\_\_\_\_

Spouse Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Notify in case of emergency \_\_\_\_\_ Relationship \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Patient referred by \_\_\_\_\_

If patient is a minor, name of responsible parent \_\_\_\_\_

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**INSURANCE INFORMATION** (Please provide copy of ID card)

Primary Insurance Name and Address: \_\_\_\_\_

Subscriber \_\_\_\_\_ Relationship to patient \_\_\_\_\_

ID Number \_\_\_\_\_ Group Number \_\_\_\_\_

Secondary Insurance Name and Address: \_\_\_\_\_

Subscriber \_\_\_\_\_ Relationship to patient \_\_\_\_\_

ID No. \_\_\_\_\_ Group Number \_\_\_\_\_

We are required to notify you of our privacy practices and offer you a copy of it.

If you wish a copy please contact our office manager.

**GENERAL CONSENT**

I hereby consent and request examination and any necessary diagnostic procedures including x-rays, blood tests, medical treatment, including immunizations and treatment deemed advisable by the physicians of The Medical Group Inc. I understand that no test will be done without my prior knowledge. I acknowledge that I have read this consent form and understand its contents. I have had an opportunity to discuss it and any questions I had have been answered to my complete satisfaction.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_