

**Internal Medicine and Pediatric Clinic of New Albany
Patient Information Sheet**

Patient's Name: (First M.I. Last)		Circle One: Mr., Mrs., Ms., Miss	
Mailing Address:			
City:		State :	Zip:
Circle One: African American		Caucasion/White	Hispanic Other
Circle One: Male		Female	Circle One: Married Divorced Widowed Single Other
Date of Birth:		Social Security Number:	
Employer		Employer's Address (If not known then at least list town)	
List all contact Phone Numbers (If # is for someone other than patient, then please write name of person beside #)			
Home: _____		Work: _____	
Cell: _____		Pager: _____	
Name of Emergency Contact and Phone Number: (Please list someone other than spouse or parent if a patient is a minor.)			
Please list your insurance information. We will need a copy of your card.			
Insurance Carrier Name & Address:			
Policy holder's Name, ID Number & Effective Date of Policy: _____			
Insurance Carrier Name & Address:			
Policy holder's Name, ID Number & Effective Date of Policy: _____			
Insurance Carrier Name & Address:			
Policy holder's Name, ID Number & Effective Date of Policy: _____			
Spouse's Name:		Spouse's Date of Birth:	
Spouse's Social Security Number:		Spouse's Employer:	
If patient is a minor child, please complete the following information. If you are a Legal Guardian instead of the parent, you will be asked for proof of guardianship.			
Father's (or Legal Guardian's) Name, DOB and SSN:			
Father's (or Legal Guardian's) Address if different from child:			
Father's (or Legal Guardian's) Employer, Employer's Address & Phone Number			
Mother's (or Legal Guardian's) Name, DOB and SSN:			
Mother's (or Legal Guardian's) Address if different from child:			
Mother's (or Legal Guardian's) Employer, Employer's Address & Phone Number			