Patient Information Sheet
Sunshine Medical Clinic

Patient's Name_____:_____Date of Birth:_____

Gender: Male_____Female_____Social Security #:_____

Street Address:_____

City:_____County:_____State:_____Zip Code_____

Phone # Home:_____Work:_____Cell:_____

Email:_____

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Parent's Information:
Mother's Name:_____Date of Birth_____
Social Security #_____
Father's Name:_____Date of Birth_____
Social Security #_____
Other:_____Relationship:_____
Social Security #_____

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Primary Insurance Company Name:_____
Member Name_____
Member Date of Birth_____
Policy #_____Group#_____
Insurance CoAddress_____

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Secondary Insurance Company Name:_____
Member Name:_____
Policy Number:_____Group#_____
Insurance Co. Address:_____

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I WILL BE PAYING TODAY BY: CASH_____CREDIT CARD_____

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PAYMENT IS DUE AT THE TIME OF SERVICE. PLEASE ASK FOR RECEIPT OF PAYMENT.

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SIGNED:_____**DATE:**_____
PLEASE PROVIDE COPY OF INSURANCE CARD. THANK YOU.