Sweet Medical Center

Patient Information

Patient Name: ____Birthdate: ___/___/_______
Last First MI
Previous/Maiden Name: ______________________________
Address: _____________________________City: ____________ State: ____ Zip: _____
Social Security Number: _________________________Gender: ____ Male ____ Female
Home Phone: ________________________Cell or Message Phone:___________________
Employer: ___________________________Marital Status: M S W D

Family and Guarantor Information

Spouse Name: ____Birthdate: ___/___/_______
Social Security Number: ___________________Employer: __________________________

If patient is a minor, please complete this section.

Father: ____Birthdate: ___/___/______
Employer: ______________________________Contact or message phone: ____________

Mother: ____ Birthdate: ___/___/______
Employer: _____________________________ Contact or message phone: ____________

In case of emergency contact

Name: _______________________________________Relationship: __________________
Phone: ____________________________

Billing Information

Name of person responsible for bill: ____
Name of insurance: ______________________ Policy holder: ________________________
Policy Number: _________________________Group Number: _______________________

Please present your insurance card at your first visit.

Consent to Treatment and Agreement to Pay

I authorize treatment of the above named & certify that the information I have provided is true and correct. I authorize Sweet Medical Center, Inc. (SMC) to release to the company which has insured me, all information regarding treatment by my healthcare provider, & I further assign to SMC all medical benefits payable under my insurance policies. I agree to pay SMC for all charges for professional services not covered by my insurance.

Signed: _____________________________________ Date: _________________________