Marshall
Rheumatology

PATIENT DATA

FORM MUST BE COMPLETED IN FULL

Patient Name: ____ DOB: ______ / ______ / ______

SSN: ___ ___ ___ - ___ ___ - ___ ___ ___ ___ Language: _______________________________________

Address: ____
Street City State Zip

Phone Numbers: Home ___________________ Cell ____________________ Work__________________

Email Address: ____

Race: ☐ American indian/Alaskan native ☐ Asian ☐ Black / African American
☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other ☐ Unknown ☐ Declined

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Declined

EMERGENCY CONTACT

Name: ____ Relationship: _________________

Phone Number: ____

RELEASE OF INFORMATION

I hereby give Marshall Rheumatology permission to release medical information (lab results, diagnosis, etc.) to the following people:

Name: ____ Relationship: _________________

Name: ____ Relationship: _________________

Name: ____ Relationship: _________________

I certify that the above information is correct. I consent to be treated by the staff and providers of Marshall Rheumatology and its affiliates. I authorize payment of medical benefits to Marshall Rheumatology and its affiliates and authorize them to release any medical information necessary to process claims. I understand that I am responsible for co-payments, deductibles, co-insurance and non-covered services.

Patient/Guarantor Signature ____ **Date** _____ / _____ / _____