2025

Sunflower Medical Group

PATIENT INFORMATION

Name:	**Date of Birth:**
Address One:	**Social Security #:**
City:	**Language:**
State: Zip:	**Primary Phys:**
E-Mail Address:	**Employer:**
Home Phone#:	**Emergency Contact:**
Work Phone#:	**Emergency Phone#:**
Cell Phone#:	**Emergency Relationship:**
Race: **Circle One: Hispanic/Non-Hispanic**	**Sex: Gender Identity:** **Sexual Orientation:**

FINANCIAL RESPONSIBILITY

Name:	**Date of Birth:**
Address One:	**Social Security#:**
City:	**Employer:**
State: Zip:	**Employer Address:**
Home Phone#:	**Employer City:**
Work Phone#:	**Employer State:**
Cell Phone#:	

INSURANCE INFORMATION

Primary Insurance:	**Secondary Insurance:**
Certificate#:	**Certificate#:**
Group Number:	**Group Number:**
Policy Holder:	**Policy Holder:**
DOB:	**DOB:**

Authorization to Pay Benefits to Physicians: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself of my Provider, Sunflower Medical Group when they accept assignment.

Authorization to Release Medical Information: I hereby authorize Sunflower Medical Group to release any information necessary for my course of treatment.

For Medicare or Medicare Replacement plans: I hereby authorize my provider to bill monthly for chronic care management services. You have the right to stop services at any time.

Acknowledgement of Privacy Notice: I acknowledge that Sunflower Medical Group's Privacy Notice, effective November 10, 2013 was made available to me.

___Yes___No Our office can leave messages to return our call on
____home answering machine,____office voice mail, _____cell #

I hereby authorize the following individuals to access my medical information

Name_____**Phone Number**_____
Name_____**Phone Number**_____

_____ _____
Signature **Date**