

**Trailside Health**  
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**HELPFUL INFORMATION FORM**

Welcome! Thank you for choosing our group. In order to serve you properly, we would like the following information. Please answer what you can. All information is confidential.

Patient Name \_\_\_\_\_ Date \_\_\_\_\_  
FIRST MI LAST  
Birthdate \_\_\_\_\_ Female \_\_\_ Male \_\_\_ SS# \_\_\_\_\_ (you may decline)  
Address \_\_\_\_\_ Home Telephone# \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ Work Telephone # \_\_\_\_\_  
Please circle your situation: Minor Single Married Widowed Divorced Separated  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Spouse's Name \_\_\_\_\_ Spouse's Employer \_\_\_\_\_  
Spouse's Work Phone \_\_\_\_\_ If patient is a student, name of school/college, city, state:  
\_\_\_\_\_  
Person to contact in case of emergency \_\_\_\_\_ Phone# \_\_\_\_\_  
Address \_\_\_\_\_  
Relationship \_\_\_\_\_ Pharmacy \_\_\_\_\_

**THE INEVITABLE INSURANCE INFORMATION... but insurance is not necessary.**

Circle here if SELF , then skip to the "Primary Insurance Co." in this section  
Name of insured \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
SS# of insured \_\_\_\_\_ (not required, but insurance won't pay without it)  
Name of insured's employer \_\_\_\_\_  
Address of Employer \_\_\_\_\_

**Primary INSURANCE Co:** \_\_\_\_\_  
Card# \_\_\_\_\_ Group# \_\_\_\_\_  
What is your co-payment amount ? \_\_\_\_\_ Effective Date \_\_\_\_\_

**Do you have ADDITIONAL INSURANCE ?** YES \_\_\_\_\_ NO \_\_\_\_\_

If 'YES', please complete the following:

**Secondary INSURANCE Co:** \_\_\_\_\_  
Card# \_\_\_\_\_ Group# \_\_\_\_\_  
What is your co-payment amount ? \_\_\_\_\_ Effective Date \_\_\_\_\_  
Name of insured \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
SS# of insured \_\_\_\_\_ (not required, but insurance won't pay without it)  
Name of insured's employer \_\_\_\_\_  
Address of Employer \_\_\_\_\_

**Authorization, release, & responsibility statement...**

I authorize the release of information and payments and am responsible for supporting this community service as outlined in the Consent to Care agreement.

Signature of patient or parent of patient \_\_\_\_\_ Date \_\_\_\_\_