



Patient Information

Please give your insurance card(s) to the receptionist.

Legal name: _____
Last First Middle

Physical Address: _____ City: _____ State: _____ Zip: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Cell: _____ Email: _____

Birth date: _____ Sex: M F Marital status: Married Single Divorced Widowed

Race: (Circle) African American Ethnicity (Circle): Hispanic or Latino
Asian Other
Caucasian Unknown
American Indian, Alaska native Declined
Native Hawaiian, Other Pacific Islander Primary language (Circle): English
Unknown Spanish
Declined Other: _____

Social Security Number: _____ Employer: _____

Employer phone: _____ Occupation: _____

Responsible Party

Please complete if patient is a minor (Under 18 years old).

Legal name: _____
Last First Middle

Mailing Address: _____ City: _____ State: _____ Zip: _____

Relationship to Patient: _____ Home phone: _____ Cell phone: _____

Email address: _____

Social Security Number: _____ Employer: _____

Employer phone: _____ Occupation: _____

Emergency Contact/Financial Release/Medical Release

I, _____, give the doctors and staff of Avera Medical Group Pierre, permission to release information to the people listed below:

(Please circle response under each column)

	Contact in case of emergency		Release medical information		Release financial information	
Name: _____	Yes	No	Yes	No	Yes	No
Relationship to Patient: _____						
Phone: _____						
Name: _____	Yes	No	Yes	No	Yes	No
Relationship to Patient: _____						
Phone: _____						
Name: _____	Yes	No	Yes	No	Yes	No
Relationship to Patient: _____						
Phone: _____						

This information is true to the best of my knowledge. I understand that I am fully responsible for payment of all services received. I authorize Avera Medical Group Pierre, or any insurance company, to release all information required to process my claims.

Patient/Guardian Signature Date