Avera Medical Group Rheumatology
6100 S. Louise Ave.
Suite 1130
Sioux Falls, SD 57108
605-504-1600

Patient Information

Name: (Last)_____ (First)_____(MI)_____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widow Occupation: _____

Sex: ❑ Male ❑ Female Date of Birth:_____ Social Security #: _____

Address:_____ e-mail address: _____

City:_____State:_____Zip: _____

Home Phone #:_____ Work Phone #:_____ Cell Phone #: _____

Employer:_____ Address: _____

Spouse's Name: _____

Spouse's Employer:_____ Work Phone #: _____

Insurance:_____ Subscriber DOB:_____

Relationship to Subscriber: _____

RESPONSIBLE PARTY/BILLING INFORMATION (if patient is a minor)

Mother's Name:_____ Birth Date:_____ Soc. Sec. No.:_____

Address:_____ Home Phone: (_____)_____
Street PO Box City/State/Zip

Employer:_____ Occupation:_____ Work Phone: (_____)_____

Father's Name:_____ Birth Date:_____ Soc. Sec. No.: _____

Address:_____ Home Phone: (_____)_____
Street PO Box City/State/Zip

Employer:_____ Occupation:_____ Work Phone: (_____)_____

EMERGENCY CONTACT

Name: (Last)_____ (First) _____

Address: _____

_____

Telephone Number: (Home)_____ (Work) _____

Relationship: _____

Patient/Guardian/POA Signature_____ Date: _____
