Avera Medical Group Internal Medicine Sioux Falls
Plaza 2
1301 South Cliff Avenue, Suite 400
Sioux Falls SD 57105
(605) 322-5750

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

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

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

Address: _____

City:_____State:_____Zip: _____

Home Phone #:_____ Work Phone #:_____

Employer:_____ Address: _____

Spouse's Name: _____

Spouse's Employer:_____ Work Phone #: _____

RESPONSIBLE PARTY/BILLING INFORMATION

Name:_____ Birth Date:_____ Soc. Sec. No.:_____

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

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

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: _____

I consent to treatment for myself or my family from Avera Medical Group Internal Medicine

Patient/Guardian/POA Signature_____ Date: _____