ENVIRONMENTAL HEALTH CENTER

Patient Information Sheet

Date:	Email Address:	Whom May We Thank for Referring You to Our Office?	Account #: (for office use)

Patient Last Name:	First Name:	MI:	Male/Female	Marital Status:

Mailing Address:	City:	State:	Zip:

Home Phone:	Cell Phone:	Date of Birth:	SS#:

Employer Information

Employer:	Employer Phone:

Employer Address:	City:	State:	Zip:

Responsible Party Information:

Name:	Mailing Address:	Zip:

Home Phone:	Relation to Patient:	Employer/Employer Ph. #:	Date of Birth:

Occupation:	# Yrs. Employed:	SS #:	Yrs. At this Address:

Emergency Contact Information:

* In Case of Emergency Contact:	Emergency Phone #:

Emergency Contact's Address:

Insurance Information

Insurance Co. #1			Insurance Co. #2		
Address:			Address:		
City:	State:	Zip:	City:	State:	Zip:
Phone:			Phone:		
Policyholder:			Policyholder:		
Group #:			Group #:		
ID #:	SS #:		ID #:	SS #:	

I consent to treatment as necessary or desirable to the care of the patient first named above, including but not restricted to whatever drugs, medicine, performance of operations and conduct of laboratory, x-ray, or other studies that may be used by the attending doctor, his nurse or qualified designate. I acknowledge that my insurance plan, if any, is between me and my insurance company and all services received from EHC-St. Louis are ultimately my financial responsibility. When appropriate, I consent to Telehealth visits to contact EHC for medical needs.

I HEREBY AUTHORIZE Tipu Sultan, MD or his staff at their discretion to limit or refuse to release any information to my insurance company, employer, or whatever entity I consent to, any information acquired in the course of my examination or treatment, including physical, mental, information on HIV, drug use, and this consent does not limit any information contained in my medical records. I hold Dr. Sultan harmless from any damage that may result from such a release or lack of release of information. If I insist that additional information must be released, I understand that Dr. Sultan and his staff will not be able to provide future medical care and I shall have find another physician for continuation of my medical care. I HEREBY AUTHORIZE PAYMENT directly to Tipu Sultan, MD/Environmental Health Center of the medical and/or surgical benefits, if any, payable to me for his services.

I HEREBY AUTHORIZE Tipu sultan, MD or his staff to mail/email/text appointment confirmation or recall notices, medical records including laboratory results as needed.

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Signature SS#:

_____Date