Sparks Family Medicine, Ltd.

10155 W. Twain Ave., Suite 110 *(702) 722-2200 Phone*
Las Vegas, Nevada 89147 *(702) 722-2201 Fax*

Advanced Directive? Yes or No

Patient's Name _____ Today's Date_____
Last First MI

Patient's Email _____

SS #_____ (_____) _____ (_____) _____
Home Phone Cell Phone

Birth Date _____ Age _____ Sex ☐ M ☐ F Marital Status ☐ S ☐ M ☐ W ☐ D

Address _____
Street Apt # City State Zip Code

Occupation _____ Employer _____ (_____) _____
Work Phone

Emergency Contact _____ Relation _____ (_____) _____

How Were You Referred to Our Office? _____

Primary Insurance _____ Plan Name _____

Insured's Name _____ _____ Gender ☐ M ☐ F
Last First MI Birth Date

Insured's SS # or ID # _____ Employer/Group # _____

Insurance Co Address _____
Street/PO Box City State Zip Phone

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Secondary Insurance _____ Plan Name _____

Insured's Name _____ _____ Gender ☐ M ☐ F
Last First MI Birth Date

Insured's SS # or ID # _____ Employer/Group # _____

Insurance Co Address _____
Street/PO Box City State Zip Phone

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Please have insurance card(s) and ID Available for Copying

I hereby authorized my insurance carrier to pay medical benefits directly to Sparks Family Medicine, Ltd. I authorize Sparks Family Medicine, Ltd. to release any medical information, including information related to psychiatric care, drug and alcohol abuse and HIV/AIDS confidential information, acquired in the course of my treatment necessary to process insurance claims or any medical information that is required for any health care related utilization review or quality assurance activities. I understand that I am financially responsible for all charges made to my account whether or not an insurance company is involved in payment. I am further responsible for all co-payment, co-insurance amounts, non-covered supplies and services, and yearly deductibles. I am also responsible for collection fees incurred by Sparks Family Medicine, Ltd. in efforts to receive payment of my financial obligations for services rendered. A photocopy of this authorization is to be considered as valid as the original, until revoked by me in writing.

Signature _____ Date _____
Patient/Parent/Guardian