Saint Mary's Center for Health
645 North Arlington Avenue, Suite 620
Reno, Nevada 89503

Tel. (775) 329-2525
Fax (775) 348-0740

(Please Print)

PATIENT INFORMATION

PATIENT NAME: _____
LAST FIRST MIDDLE

DATE OF BIRTH: _____ SEX: ___FEMALE ___MALE

ADDRESS: _____

ZIP CODE: _____ CITY: _____ STATE: _____

RESPONSIBLE PARTY INFORMATION

MOTHER'S NAME: _____
LAST FIRST MIDDLE

DATE OF BIRTH: _____ SOCIAL SECURITY#: _____

ADDRESS: _____

ZIP CODE: _____ CITY: _____ STATE: _____

HOME PHONE#: _____ WORK PHONE#: _____

E-MAIL: _____ CELL PHONE#: _____

FATHER'S NAME: _____
LAST FIRST MIDDLE

DATE OF BIRTH: _____ SOCIAL SECURITY#: _____

ADDRESS: _____

ZIP CODE: _____ CITY: _____ STATE: _____

HOME PHONE#: _____ WORK PHONE#: _____

E-MAIL: _____ CELL PHONE#: _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: _____

SUBSCRIBER'S NAME: _____ SUBSCRIBER'S ID#: _____

SUBSCRIBER'S DATE OF BIRTH: _____ RELATIONSHIP TO PATIENT: _____

SUBSCRIBER'S EMPLOYER: _____ GROUP#: _____

SECONDARY INSURANCE COMPANY: _____

SUBSCRIBER'S NAME: _____ SUBSCRIBER'S ID#: _____

SUBSCRIBER'S DATE OF BIRTH: _____ RELATIONSHIP TO PATIENT: _____

SUBSCRIBER'S EMPLOYER: _____ GROUP#: _____

ARE YOU SEEKING OR PENDING MEDICAID? ___**YES** ___**NO** ___**INT'L**