

**Sun Lake Medical Associates**  
18964 N Dale Mabry Hwy                      Lutz, Florida 33548

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Office use only	Acct #	Chart#
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**PATIENT INFORMATION SHEET**

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Apt. # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

SSN \_\_\_\_\_ Date of Birth \_\_\_\_\_

Age \_\_\_\_\_ Sex \_\_\_\_\_ Height \_\_\_\_\_ Marital Status \_\_\_\_\_

Home Phone # (     ) \_\_\_\_\_ Work ph# \_\_\_\_\_ Cell ph# \_\_\_\_\_

Email Address: \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employer's address \_\_\_\_\_

Name of spouse or parent \_\_\_\_\_ Relationship \_\_\_\_\_

Their address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Their employer \_\_\_\_\_ Occupation \_\_\_\_\_

Their employer's address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Primary Insurance Company: \_\_\_\_\_ Member ID # \_\_\_\_\_

Self Insured: YES \_\_\_\_\_ NO \_\_\_\_\_

Allergies to medication    Yes    /    No

If Yes

\_\_\_\_\_  
\_\_\_\_\_

List of Current Medication: \_\_\_\_\_

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Patient's or authorized person's signature. I authorized the release  
Of any medical information necessary to process this claim. I also  
Request payment of government benefits either to myself or to  
The party who accepts the assignment

I authorized payment of medical benefit to  
undersigned physician or supplier for service  
described.

Signed

Date

Signed (insured or authorized Person)