

Linda R. Olafson, M.D., FAAFP
Patient Information Sheet

Name _____

Date of Birth _____ Age _____ Gender: Male Female

Job Title _____

Nature of Business _____

Employer _____

Employer Phone _____

Home Address Street _____

City _____ State _____ Zip _____

Home Phone _____

Work Phone _____

Cell Phone _____

Fax _____

Email _____

Emergency Contact

Name _____

Address _____

City _____ State _____ Zip _____

Who referred you to this practice? _____

Please complete the following if the patient is not the subscriber on the insurance.

Insurance Name _____

Subscriber _____ SS# _____

DOB _____ Employer _____

ID# _____ Group# _____ Phone _____

Financial Policy: Payment for professional fees is due in full at the time service is provided.

Your signature below demonstrates that you understand our financial policy, agree to allow the doctor to bill your insurance company (when appropriate) and release necessary medical information to the insurance company. Your signature also gives your consent for medical treatment.

Signature _____ Date _____