



**Oklahoma Medical Research Foundation
Multiple Sclerosis Center of Excellence**
820 Northeast 15th Street
Oklahoma City, OK 73104
405-271-6242
Fax: 405-271-2887
omrf.org/MSCenter

PATIENT INFORMATION

(Please use legal name)
PLEASE PRINT CLEARLY

Name of Patient _____ Birth Date ____/____/____

(Last) (First) (MI)
Age: _____ Gender: Male Female Social Security #: ____/____/____

Home Address: _____
(Street) (City) (State) (Zip)

Mailing Address: _____
(Street) (City) (State) (Zip)

Cell Phone #: _____ Home Phone #: _____

E-mail address: _____ Language: _____ Interpreter Needed? _____

Employer: _____ Work Phone#: _____ Ext. _____

Emergency Contact: _____ Home Phone # (____) _____
(Name) (Emergency Contact)

Relationship to Patient: _____ Cell Phone # (____) _____
(Emergency Contact)

Referring Physician: _____ Phone #: _____

Primary Care Physician: _____ Effective Date: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone #: (____) _____

Insurance Information: We will need a copy of the insurance card in order to file a claim.

Primary Insurance Coverage: _____ Policy #: _____

Group #: _____ Insured Name: _____

Male Female DOB: _____ SSN#: _____

Relationship to Patient: _____ Primary Insured Employer: _____

Secondary Insurance Coverage: _____ Policy #: _____

Group #: _____ Insured Name: _____

Male Female DOB: _____ SSN#: _____

Relationship to Patient: _____ Primary Insured Employer: _____

Guarantor Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: (____) _____

Marital Status: _____ Family Members:

Name: _____ DOB: _____ Name: _____ DOB: _____

Name: _____ DOB: _____ Name: _____ DOB: _____

Patient/Signature:

I hereby apply for treatment by the physicians of this practice and or their assistants. I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf and I assign the benefits payable to which I am entitled to this practice. I understand that payment is due at the time of service and that I am financially responsible for all charges, whether or not paid by insurance.

Signature: _____ **Date:** ____/____/____