Robison Clinic

1415 North Watts - Sayre, OK 73662

Phone: (580) 928-2044 • Fax:

Patient Information

Name: (First, Middle, Last) ______________________ Date of Birth: ____________

Mailing Address: ______________________ (City, State, Zip): ____________

Social Security #: ____________ Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Home Phone: ________ Cell Phone: ________ Work Phone: ________ Preferred Name: ________

Email: ____________ Race: ________________________

Employment Information

Employer: ______________________ Occupation: ____________

Address: ______________________ (City, State, Zip): ____________

Responsible Party Information

Name: ______________________ Date of Birth: ____________

Address: ______________________ (City, State, Zip): ____________

Social Security #: ________ Responsible Party's Phone #: ________ Relationship to Patient: ________

Occupation: ________ Employer: ________ Employer Phone: ________

Insurance Information

Name of Insured: ______________________ Relationship to Patient: ____________

Insured's Date of Birth: ________ Social Security #: ________ Phone: ________

Insurance Company: ________ Group #: ________ ID Number: ________

Address: ______________________ (City, State, Zip): ____________

Spouse Information

Name: (First, Middle, Last) ______________________ Date of Birth: ____________

Address: ______________________ (City, State, Zip): ____________

Social Security #: ________ Employer: ________ Employer Phone: ________

Relative to Contact in Case of Emergency

Name: ________ Phone: ________ Relationship to Patient: ________

Address: ______________________ (City, State, Zip): ____________

Is Your Illness or Injury Related to Any of the Following?

☐ Employment ☐ Emergency ☐ Accident ☐ Auto Accident (State of Auto Accident) ____________

If Employment related, has employer been notified? ☐ Yes ☐ No Employer Contact Name: ____________

Employer Contact Phone and Extension: ______________________

HIPAA Notification

I acknowledge that I have recieved The Robison Clinic notice of privacy practices.

Signature of Patient or Other Legally Authorized Person:____Date:__________________

Consent to Treatment / Financial Responsibility and Assignment of Benefits

I voluntarily consent to receive medical and health care services that may include diagnostic procedures, examination, and treatment.

I hereby assign, transfer, and set over to Robison Clinic all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

I certify that I have read this form and understand its contents.

Patient or Other Legally Authorized Person: ______________________ Date: ____________