CLAY-PLATTE FAMILY MEDICINE CLINIC, PC

PATIENT INFORMATION FORM

Partnering for Excellence in Health Care

Date _____

Name First _____ M.I. _____ Last _____

Address _____ Apt._____ City _____ State ____ Zip_____

Home Phone _____**Cell Phone** _____ **E-mail** _____

SSN _____ **Date of Birth** _____ **Sex**: M or F **Marital Status**: S M D W

Patient's Employer _____ **Phone** _____

Race □White □Hispanic/Latino □ American Indian /Alaskan Native □Asian
□ Black /African American □Native Hawaiian /Other Pacific Islander □ Other

Language Preference_____ **Hearing Impaired** □Yes □ No **Vision Impaired** □ Yes □ No

Preferred Contact Method □ Phone □Email □Mail **Need Interpreter?** □ Yes □ No **Type** _____

How did you hear about Clay Platte Family Medicine?
□Insurance □Family Member □Friend □Print Ad □Billboard □Website □Phonebook
□ Other Specify _____

Person Responsible for Account

Name First _____ M.I. _____ Last _____

Address _____ Apt._____ City _____ State ____ Zip_____

SSN _____ **Home Phone** _____ **Cell Phone** _____

Employer _____ **Phone** _____

Relationship to Patient _____

Primary Insurance

Insurance Plan _____ Effective Date _____ Co-Pay _____

Policyholder Name _____ Relationship to Patient _____

Address _____ City _____ State _____ Zip_____ Phone_____

Policyholder Date of Birth _____ Policyholder SSN _____

Policyholder Employer_____ Phone _____

Secondary Insurance

Insurance Plan _____ Effective Date _____ Co-Pay _____

Policyholder Name _____ Relationship to Patient _____

Address _____ City _____ State _____ Zip_____ Phone_____

Policyholder Date of Birth _____ Policyholder SSN _____

Policyholder Employer_____ Phone _____

Turn Page Over

Spouse/Parent/Guardian Information

Name First _____ M.I. _____ Last _____

Address _____ Apt._____ City _____ State ____ Zip_____

Home Phone _____ Cell Phone _____ Work Phone _____

Relationship to Patient _____

Emergency Contact Information

Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship _____

Privacy Information – Please read our privacy notice to understand who we may release your protected health information to as allowed by law.

1. May we have your permission to leave messages regarding appointments or requests for your call back on an answering machine? Yes _____ No _____ Cell phone: Yes _____ No _____
2. To whom may we release protected health information? (Choose One)

   _____ To **myself** only; (RPO)

   _____ To myself and **anyone** else involved in my healthcare or payment for my healthcare (i.e., caregivers, family members;) (NORES)

   _____ To myself and **Only** to the following designated persons; (IRC)

   Name _____ Relationship _____

   Name _____ Relationship _____

   Name _____ Relationship _____

Assignment of Insurance Benefits/Release of Medical Information

I understand pre-certifications/authorizations/referrals are my responsibility.

I hereby authorize treatment deemed necessary by the above named physicians. I also authorize the release of my medical records to any insurance company with whom I have health insurance coverage or to any company to which I have applied for coverage. I request payment of medical insurance benefits to include major medical to be made directly to **CLAY PLATTE FAMILY MEDICINE** on any unpaid bills for services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

Signed _____ Parent/Guardian _____

Date _____

CLAY-PLATTE FAMILY MEDICINE CLINIC
PATIENT HISTORY FORM

NAME _____ DOB _____ Age _____ Date _____

List all current medical problems:

List All Hospitalizations /Surgeries and illness/injuries out of the hospital (use back of form for additional space)	
Date	Problem

Habits				
Smoking/Tobacco	No	Yes	If yes, how much	Previously
Drinking Alcohol	No	Yes	If yes, how much	Previously
Recreational Drugs	No	Yes	If yes, how much	Previously
Exercise	No	Yes	If yes, how much	What Type

List all Medications previously and current Herbal Supplements/Vitamins/Over-The-Counter Medications

CURRENT/DOSE	CURRENT/DOSE	PREVIOUS

Immunizations/Dates:	Tetanus	Hep B	Pneumovax
For Children, Need Immunization Record			

Allergies: (Medication and Type of Reaction)

FAMILY HISTORY (Note Cancer (type), TB, High Blood Pressure, Heart Trouble, Stroke, Diabetes, Seizure, Asthma, other)	
Mother	Father
Maternal Grandfather	Paternal Grandfather
Maternal Grandmother	Paternal Grandmother
Sister/Brother	Aunts/Uncles
Children	Other

Social History				
Single	Widowed	Divorced	Married	Separated
No. Children at home	Parents at Home			

Current Occupations:	Education Level: