PATIENT INFORMATION

NAME: _____ **DOB:** _____
First *MI* *Last*

SSN: _____ **GENDER**: Male/Female **MARITAL STATUS**: S / M / D / W

MAILING ADDRESS: _____
City *State* *Zip*

****CONTACT PHONE NUMBERS**

HOME: (_____)_____-_____ CELL: (_____)_____-_____ WORK: (_____)_____-_____

***RACE: (check one)**

_____American Indian or Alaskan Native

_____ Asian

_____ Black or African American

_____Native Hawaiian or other

_____ White

_____ Refuse to report

***ETHNICITY: (check one)**

_____ Hispanic or Latino

_____ Non Hispanic or Latino

_____ Refuse to report

PREFERRED LANGUAGE: _____

PREFERRED PHARMACY: _____

***PREFERRED COMMUNICATION METHOD: (circle one)**

Email Phone US Mail Patient Portal

***GUARANTOR (Parent or Person Responsible for bill)**

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____
City *State* *Zip*

PHONE NUMBER: (_____)_____-_____

***EMERGENCY CONTACT**

NAME: _____ RELATIONSHIP: _____

PHONE NUMBER: (_____)_____-_____

***** The below representatives are whom I agree to permit Clayton Family Practice to disclose protected health information. The nature of the disclosures includes, but is not limited to my condition, treatment, financial, and healthcare operations unless restrictions are noted.**

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

*****I understand I have the right to revoke the consents at any time. I further authorize you to contact the above named individuals regarding personal protected health information.**

_____ _____
Signature ***Date***

NAME: _____ DATE: _____

INSURANCE INFORMATION

Primary Insurance Company Name: _____

Member ID: _____ Group #: _____

Secondary Insurance Company Name: _____

Member ID: _____ Group #: _____

I authorize and direct my insurance company to pay medical, and/or surgical benefits directly to Clayton Family Practice to apply to my account. A photo static copy of this authorization shall be considered as effective and valid as the original. This authorization applies to any policy effective at the time professional services are rendered. I understand that I am financially responsible to Clayton Family Practice for physicians* fees not covered by insurance benefits.

_____
SIGNATURE

***** IT IS OUR POLICY TO CHARGE A $30.00 FEE FOR ANY CHECK THAT IS RETURNED FOR INSUFFICIENT FUNDS. THIS FEE MAY BE INCREASED IN THE FUTURE.**

I authorize that Clayton Family Practice exchange my immunization data with the statewide immunization registry.

_____
SIGNATURE

I authorize that my health information be shared with another healthcare professional when my physician deems necessary, ie; Referral or Physician to Physician consult.

_____
SIGNATURE

I authorize my medication information to be shared with Clayton Family Practice via the Rx hub

_____
SIGNATURE

I _____hereby acknowledge Clayton Family Practice notice of privacy practices. (*These can be found posted on the wall next to the reception window, a copy will be provided if requested*.) This notice describes how Clayton Family Practice may use and disclose my protected health information, certain restrictions on the use and disclosure of my health care information, and rights I may have regarding my protected health information.

_____
SIGNATURE

***** PATIENT CANNOT AUTHORIZE BECAUSE**:** _____

***** RELATIONSHIP TO PATIENT: _____