Primary Care Provider
Address
Phone

Patient's personal information

First name	Middle Initial	Last name
Date of birth:	Gender:	
Street address:		
City:		
State:		
Zip Code:		
Email:		
Phone:		

What is the patient's marital status? Check one.

☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widow ☐ Widower

Insurance

Insurance company name:
Insurance plan:
Member ID
Group ID
Effective date:
Subscriber: First Name Last DOB:
Subscriber's phone #:
Guarantor's Social Security #:

Preferred language

Emergency contact information

First Name Last Name
Address:
City:
State:
Zip code:
Phone:
Email:

Chief complaint

Allergies	**Describe kind of reaction**

Smoking Status: ☐ **Current** ☐ **Quit** ☐ **Never** If smokes cigarettes how many packs per day? _____ or specify what type of tobacco used_____

Preferred Pharmacy

Name:	City:	State:

Medications name and dose

Major surgeries/hospitalizations/events and dates

Patient's signature

SIGNATURE OF PATIENT OR PATIENT AUTHORIZED REPRESENTATIVE
Relationship to patient if other than patient:
Date:

Are you currently or ever been treated for any of below medical conditions?

Yes	No	Condition	Explain
		Asthma	
		Sleep disorders	
		Sickle Cell Disease	
		Diabetes	
		Thyroid	
		Hypertension	
		High cholesterol	
		Gastrointestinal problems	
		Ear/sinuses	
		COPD	
		Kidney disease	
		Menstrual problems	
		Seizures	
		Migraines/headaches	
		Heart attack	
		Heart disease	
		Vascular	
		Heart murmur	
		Fainting	
		Bleeding Disorders	
		Cancer	
		Serious Injury	
		Learning Disorders	
		Fatigue	
		Glaucoma	
		Other (specify)	

Assignment of Insurance Benefits

The undersigned authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I agree that my signature authorizes Family Health Care & Walk In Center to submit claims for benefits for services rendered, without obtaining my signature on each one.

I hearby authorize my insurance company(ies) to pay and hereby assign directly to Family Health Care & Walk In Center. all benefits, if any, otherwise payable to me for the services as described on the attached forms. I understand I am financially responsible for all charges incurred. Any insurance benefits, when paid to and received by Family Health Care & Walk In Center will be credited to my account.

SIGNATURE OF PATIENT OR PATIENT AUTHORIZED REPRESENTATIVE
Date

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General Consent and Disclosure.

The information in this consent is given so that you will be better informed about the health care services you will receive. FAMILY HEALTH CARE & WALK IN CENTER cannot assume the responsibility for payment of medical care received outside of this clinic. You the patient or legal guardian is responsible for any fees incurred during your care not covered by your health insurance.

Disclaimer on Screening:

FAMILY HEALTH CARE & WALK IN CENTER uses screening tests which are a way to find people who may develop certain common medical problems. Screening tests are valuable because they can find disease early before it becomes a big health problem. Screening tests do not cover all diseases and may miss some diseases they are supposed to find. The test results are not final, just one part of a complete exam. Screening tests can alert you to promptly seek care pertaining to that finding to minimize risk and or resolve the issue.

GENERAL CONSENT: In addition to the above general consent, I understand that special consent forms must be read and signed for the following procedures; Immunizations, HIPPA privacy Notice.

DISCLOSURE OF INFORMATION: FAMILY HEALTH CARE & WALK IN CENTER may disclose health information about you when: a law requires the use of disclosure, to provide, coordinate, or manage healthcare or related services. This includes providing care to you, consulting with another health care provider, to a public health authority for the purpose of preventing or controlling disease, to a person who may have been exposed to a communicable disease or who is at risk of contracting or spreading a disease condition.

Questions: I certify that this form has been fully explained to me, that any blank lines have been filled in and that any questions I have had about the services have been answered to my satisfaction.

Signature section:

Patient's name:

Patient's or guardian's signature:

Name of guardian:

Relationship of guardian to patient	**Date:**

HIPAA COMPLIANCE PATIENT CONSENT FORM

Our notice of privacy practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The term of the notice may change, if so, you will be noticed at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health insurance Portability and Accountability Act of 1996) law allows for the use of information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing sign by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with members of your family?	YES	NO

If yes, please name the members allowed:

_____

_____

This consent was signed by: _____

(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____