FAMILY MEDICAL CENTER

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PATIENT INFORMATION:

Patient's Name _____ Marital Status _____SS# _____

Mailing Address _____City/State _____Zip _____

Birth date _____Age _____Male/Female _____ Phone # _____

Employer_____Occupation_____Work # _____

Do you have an Advanced Directive (Living Will): ☐ Yes ☐ No Pharmacy _____

IF PATIENT IS A MINOR OR STUDENT:

Mother's Name _____ Birth date _____ SS# _____

Address _____ Phone# _____

Father's Name _____ Birth date _____ SS# _____

Address _____ Phone# _____

INSURANCE INFORMATION:

Primary Ins Company _____ ID#_____ Group # _____

Policy Holder's Name_____ Employer_____ DOB _____

Secondary Ins Company _____ ID#_____ Group # _____

Policy Holder's Name_____ Employer_____ DOB _____

EMERGENCY CONTACT (Person out of the Home)

Name _____ Phone#_____ Relationship _____

CONSENT AND AUTHORIZATION:

I hereby give my consent and authorization for Family Medical Center to use or disclose my personal health information as they see fit. I understand I have the right to review the provider's privacy notice, to request restrictions and to revoke this consent at any time. This consent and authorization is valid for Family Medical Center. I also authorize and request that payment under my insurance programs be made directly to the above provider for any services furnished to me. I understand even though I have insurance, I am responsible for payment.

Signed_____Date_____