HealthFirst Medical Group
Patient Information Sheet

Date: ____ /____ /____

Patient's Name: _____
Last First Middle Initial

Mailing Address: _____
Street Apt. No. City State Zip Code

Preferred Daytime Contact No.: _____

Home Phone No.: _____ Work Phone No.: _____

Birth Date: ____/____/____ Age: _____ Sex: M or F (Circle One) Married Single Separated Divorced Widowed

Employment Status: Full Time Self Employed Retired Part Time Unemployed Full Time Student
Military (Active or Retired)

Social Security No.: _____ Driver License No.: _____ State: _____

Referred By: _____

Employer: _____ Work Phone No.: _____

In case of emergency, contact name: _____ Phone No.: _____
(Person outside of your household)

If Patient is a Minor:

Guardian's Name: _____ Birth Date: _____ S.S. No.: _____

INSURANCE INFORMATION

PLEASE PRESENT INSURANCE CARD TO RECEPTIONIST

Primary Insurance Company Name: _____

Insured Name: _____ Birth Date: ____/____/____ Sex: M or F

Social Security No.: _____ I.D. No.: _____ Group No.: _____

Doctor Listed on Card: _____ Effective Date of Insurance: _____

Employer: _____ Phone No.: _____

Relationship to Patient: (Circle One) Self Spouse Child Parent

Secondary Insurance Company Name: _____

Insured Name: _____ Birth Date: ____/____/____ Sex: M or F

I.D. No.: _____ Group No.: _____

Employer: _____ Phone No.: _____

Relationship to Patient: (Circle One) Self Spouse Child Parent

OVER

AUTHORIZATION AND ACKNOWLEDGEMENT

I AUTHORIZE THE PHYSICIAN'S OFFICE TO FURNISH MY INSURANCE COMPANY ANY INFORMATION DURING THE COURSE OF MY EXAMINATION OR TREATMENT.
I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES AND THAT FULL PAYMENT IS DUE AT THE TIME OF SERVICE. IN THE EVENT THAT THE PHYSICIAN'S OFFICE SHOULD ELECT TO FILE INSURANCE ON MY BEHALF FOR SERVICE RENDERED, I REQUEST THAT PAYMENT BE MADE DIRECTLY TO THE PHYSICIAN'S OFFICE.

RELEASE OF YOUR PRIVATE HEALTH INFORMATION

_____YES, I authorize _____ NO, I do not authorize

HealthFirst to discuss my medical history. Diagnosis, treatment and prognosis with those listed below. I understand this may include information regarding testing, examination and treatment for HIV, AIDS, related illness, mental health and drug, alcohol or chemical abuse.

Spouse _____

Children _____

Parents _____

Other _____

I CONSENT TO TREATMENT AND MEDICAL CARE BY THE PROVIDERS OF HEALTHFIRST MEDICAL GROUP.

ADVANCED DIRECTIVES ARE AVAILABLE UPON REQUEST. (DNR & LIVING WILLS)

I authorize release of all information necessary to a specialist should I be referred for medical care.

Signature: _____ Date:____/____/____
(Parent, if Minor)

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of HealthFirst Medical Group's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice and I request the following restriction(s) concerning the use of my personal medical information:

_____

Further, I permit a copy of this authorization to be used in place of the original.

Signed: _____ Date:____/____/____

Internal Use Only:
If patient or patient's representative refuses to sign acknowledgement of receipt of notice, please document who it was presented to, the date, and time it was presented, sign where indicated, and present to your supervisor immediately for review.

Presented on (date and time): _____

By (name and title): _____

Supervisor (name and title): _____