



CLAY-PLATTE FAMILY MEDICINE CLINIC, PC  
**PATIENT INFORMATION FORM**  
*Partnering for Excellence in Health Care*

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

Hearing Impaired?  Yes  No Vision Impaired?  Yes  No Language Preference \_\_\_\_\_

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  
Specify \_\_\_\_\_  Billboard  Website  Phonebook  Other

**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**

**Parent/Guardian or Spouse 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 \_\_\_\_\_

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

1. May we have your permission to leave messages regarding appointments, or requests for you to call us back, on your answering machine? Yes \_\_\_\_\_ No \_\_\_\_\_
2. May we release protected health information to a care giver, family member, or others involved in your health care or payment for your healthcare? Yes \_\_\_\_\_ No \_\_\_\_\_

If you answered “No” to #2:  
Please list specific individuals who may receive protected health information.

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

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**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 including 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 \_\_\_\_\_

AUTHORIZATION FOR THE USE AND DISCLOSURE OF  
PROTECTED HEALTH INFORMATION TO:  
*Clay-Platte Family Medicine Clinic, PC*

I, \_\_\_\_\_ born \_\_\_\_\_, consent to and authorize \_\_\_\_\_ to furnish to

*Clay-Platte Family Medicine Clinic, PC*  
*5501 NW 62<sup>nd</sup> Terrace, Suite 100*  
*Kansas City, MO 64151*

the following medical records and information: \_\_\_\_\_  
\_\_\_\_\_(Specify patient name, admission date or period concerned)

for the following purpose(s): \_\_\_\_\_  
\_\_\_\_\_ (list all purposes).

I specifically authorize the release of types of information initialed below:

\_\_\_\_\_ Alcohol and drug abuse treatment \_\_\_\_\_ Mental health  
\_\_\_\_\_ Genetic Information \_\_\_\_\_ HIV status or AIDS

I understand this authorization may be revoked in writing at any time except to the extent already acted upon. To revoke this authorization I must send a request in writing to Clay-Platte Family Medicine Clinic, PC at the above address. **This authorization expires on \_\_\_\_\_** (date of event) or within one (1) year of the date signed if I have not provided an expiration date or event. I understand that treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. If medical records or correspondence from providers is provided pursuant to this authorization, Clay-Platte Family Medicine Clinic, PC cannot attest to the accuracy or completeness of the information.

I authorize the release of my records relating to: (check one):

\_\_\_\_\_ Treatment rendered prior to the date this authorization is signed  
\_\_\_\_\_ Treatment rendered both before and after the date this authorization is signed  
\_\_\_\_\_ Treatment rendered only after the date this authorization is signed

I understand that my information used or disclosed pursuant to this authorization may be redisclosed by the recipient and may no longer be protected by the Privacy Regulation. A photostatic copy of this authorization shall be considered as effective and valid as the original. I also understand that a photocopy charge will be incurred for all requests except those directed to a physician or health care facility.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

If Personal Representative, Relationship to Patient \_\_\_\_\_

The information disclosed to you may be from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules and state law prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

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	No	Yes	If yes, how much	Previously
Drinking Tea	No	Yes	If yes, how much	Previously
Drinking Coffee	No	Yes	If yes, how much	Previously
Drinking Alcohol	No	Yes	If yes, how much	Previously
Marijuana	No	Yes	If yes, how much	Previously
Recreational Drugs	No	Yes	If yes, how much	Previously
Other (snuff, etc)	No	Yes	If yes, how much	Previously

List all Medications previously and current	
CURRENT	PREVIOUS

Immunizations dates:	Tetanus	MMR	Polio	Hepatitis	Flu	Pneumovax	Other
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Allergies

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

Social History (please indicate " Yes or No")				
Single	Widowed	Divorced	Married	Separated
No. Children at home	Parents at Home	Family Stress	Job Stress	
Vacation Taken Last 12 Months	Weeks	Marriage Stress		

Occupations
Current
Previous
Previous