



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

Date _____
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
Language Preference _____ Hearing Impaired Yes No Vision Impaired Yes No
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 Billboard Website Phonebook
 Other Specify _____

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

Spouse/Parent/Guardian 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 _____

Name _____ Phone _____ Relationship _____

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

1. May we have your permission to leave messages regarding appointments or requests for your call back on an answering machine? Yes _____ No _____ Cell phone: Yes _____ No _____

2. To whom may we release protected health information? (Choose One)

_____ To **myself** only; (RPO)

_____ To myself and **anyone** else involved in my healthcare or payment for my healthcare (i.e., caregivers, family members;) (NORES)

_____ To myself and **Only** to the following designated persons; (IRC)

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

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 to include 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 _____

**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/Tobacco	No	Yes	If yes, how much	Previously
Drinking Alcohol	No	Yes	If yes, how much	Previously
Recreational Drugs	No	Yes	If yes, how much	Previously
Exercise	No	Yes	If yes, how much	What Type

List all Medications previously and current Herbal Supplements/Vitamins/Over-The-Counter Medications

CURRENT/DOSE	CURRENT/DOSE	PREVIOUS

Immunizations/Dates: Tetanus Hep B Pneumovax

For Children, Need Immunization Record

Allergies: (Medication and Type of Reaction)

FAMILY HISTORY (Note Cancer (type), TB, High Blood Pressure, Heart Trouble, Stroke, Diabetes, Seizure, Asthma, other)

Mother	Father
Maternal Grandfather	Paternal Grandfather
Maternal Grandmother	Paternal Grandmother
Sister/Brother	Aunts/Uncles
Children	Other

Social History

Single	Widowed	Divorced	Married	Separated
No. Children at home	Parents at Home			

Current Occupations: _____ Education Level: _____