Bradley-Polk Walk-In Clinic

PATIENT INFORMATION

(PLEASE PRINT)

Relationship to Patient: Self Parent Spouse

Patient's First Name: _____ Middle: _____ Last: _____

Address: _____ City: _____ State/Zip: _____

Social Security Number: _____ Marital Status: Single Married Divorced Widowed

Date of Birth: _____ Age: _____ Sex: Male Female

Home Phone (___)_____Secondary Phone (___)_____Cell Phone (___)_____

Nearest Relative or Friend (other than spouse): _____ Phone:_____

Employer/School: _____ Employer Phone Number: (___)_____

Employer Address: _____ Occupation: _____

Spouse's Name: _____Employer:_____

Address: _____Employer Phone Number: (___)_____

Relationship if a Child: Mother Stepmother Guardian

Name: _____ Social Security Number: _____

Birthdate: _____ Home Phone: (___)_____ Cell Phone: (___)_____

Work Phone: (___)_____Employer: _____ Occupation: _____

Relationship if a Child: Father Stepfather Guardian

Name: _____ Social Security Number: _____

Birthdate: _____ Home Phone: (___)_____ Cell Phone: (___)_____

Work Phone: (___)_____Employer: _____ Occupation: _____

Name of any family member who has been a patient here: _____

Family Physician: _____ City/State: _____ Phone: _____

Patient Consent for Provider to Use or Disclose Health Information for Treatment, Payment, and Health Care Operations: I understand by signing this document that Bradley-Polk Walk-In Clinic may use and disclose my personal health information to help provide health care, to handle billing and payment, and to take care of other health care operations. A detailed document called the "Notice of Privacy Practices" containing more information about the policies and practices used to protect our patients is available upon request. Under the terms of this consent, I can ask to restrict how my personal health information is used or disclosed to carry out treatment, payment, or health care operations. I understand that Bradley-Polk Walk-In Clinic does not have to agree to my request, but will follow the agreed limits. I have the right to cancel this consent in writing at any time. Canceling this consent would not effect the information already used or disclosed. I understand if I cancel this consent, Bradley-Polk Walk-In Clinic does not have to provide any further health care services to me.

****Please list below any person that you allow us to disclose medical information to; this includes, but is not limited to, appointment times, lab results, his/her provider's plan for healthcare, etc.**

Name: _____ Relationship: _____ Name: _____ Relationship: _____

***May we leave lab results, appointment reminders,etc. on your home answering machine? Yes No**

Cell Phone (___)_____ Yes No Patient/Guardian Signature: _____

Person Responsible for the Bill (If other than Patient)

Name: _____ Phone: (___)_____

Address: _____

The patient (guardian) agrees to notify this office if any changes occur in the medical/health history. The patient (guardian) agrees to be fully responsible for payment of services rendered in this office, excluding any negotiated or contracted amounts from PPO/HMO insurance company that must be written off of account and are not the patient's responsibility. I am also responsible for any attorney's fees and costs of collections in the event of default. I authorize the release of any medical information necessary to process my insurance claim and request payment of benefits to the provider for the services described.

Signature: _____ Date: _____

INSURANCE INFORMATION

****Please present insurance card to secretary when handing information sheet in****

PRIMARY INSURANCE

Insured's Name: _____ Relationship to Patient: _____

Insured's Social Security Number: _____ Insured's Date of Birth: _____

Insured's Employer: _____

Insured's Company: _____

Mailing Address for Medical Insurance Claims: _____

Identification Number: _____ Group Number: _____

Effective Dates: _____ Co-pay Amount: _____

Deductible: YES NO

Is referral or prior authorization required before services can be rendered? YES NO

SECONDARY INSURANCE

Insured's Name: _____ Relationship to Patient: _____

Insured's Social Security Number: _____ Insured's Date of Birth: _____

Insured's Employer: _____

Insured's Company: _____

Mailing Address for Medical Insurance Claims: _____

Identification Number: _____ Group Number: _____

Effective Dates: _____ Co-pay Amount: _____

Deductible: YES NO

Is referral or prior authorization required before services can be rendered? YES NO

Bradley-Polk Walk-In Clinic
EHR Authorization Form

As part of our electric health record (EHR), we are able to provide you with access to your record. The information you can access by supplying us with your email address. If you do not have an email address and would like the information, you may request the information be printed out for you. In addition to being able to access your records, we can also text message reminders about upcoming appointments if you have a cell phone and desire such reminders. Please sign below indicating which (if any) of these services you would like to receive. Thanks for allowing us to be part of your medical care.

____ I would like to be able to access my medical records. My email address is supplied below:

_____

____ I do not desire to access my medical records and do not want to supply an email address.

_____ I would like to receive text message reminders of upcoming appointments. My cell phone number is: _____

_____ I do not desire to receive text message reminders of upcoming appointments.

Signature of patient/guardian: _____

Date: _____