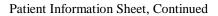


Patient Information Sheet

Patient Information				
Last Name	First Name		MI	
Address	City		State	
Home Phone_	Cell	Wo	rk	
Email	Date of Birth		Gender	
Marital StatusMarriedSingleWidowedDivorcedSeparated Social Security Number				
RaceAmerican IndianAsia	anBlack or African Amo	ericanNative Hawaiian	WhiteOther	
EthnicityCambodianFilipinoHispanic/LatinoNon-Hispanic				
Dependent? If yes, Guard	lian's Name			
Address	Phone			
Responsible Party		Address		
City	State	Relationship to Patient		
Employer				
Employment StatusEmployed _	Self-employedRetired	On active military duty	Unknown	
Employer NameEmployer Address				
Employer phone	Positio	n		
Emergency Contact Information				
Name Relationship to Patient				
Home or Work Phone	Cell Number			
Insurance				
Primary Insurance Carrier	Addres	ss		
Insured's Name	Relationship to Patient			
Insured's ID Number	Group Number			
Preferred Method of Contact				
Preferred Method of Contact Pho	neEmailPatient P	PortalOther		
Do we have your permission to leave a detailed message including test results?YesNo				
Phone number to leave messages Email to leave messages				
	Signatu			
I verify that the above information is fac if applicable, is due at the time of service	tual and true to the best of my		roof of insurance and/or copa	
Patient or Legal Guardian Signature		Date	e	





Pharmacy Information			
Pharmacy Name	Address		
Pharmacy Phone Number			
Authorization	on to Release Medical Information		
Please check one			
I authorize One to One to release my medical inf	Formation including the diagnosis, examination rendered to me, treatment to:		
Spouse Child(ren)	Other		
Information is not be released to anyone.			
This release of information will remain in effect until t	terminated by me in writing.		
General Consent to Treat			
and minor procedures. I acknowledge and agree no g understand that State Law requires physicians to report If at any time I have questions about my examination, answered to that I am fully informed. I understand the proper diagnosis and treatment. I understand complet treatment prescribed. I authorize one to one Health to release my health info health plan for purposes of advising me concerning ap in my records. I authorize One to One Health to release administration, including receiving or making payment.	taff for my healthcare, including but not limited to exams, testing, medications, guarantees have been made to me as the results or outcome of my care. I set certain communicable diseases to the Health Department. diagnosis, or treatment, I will not proceed until my questions have been at giving the providers and nurses all relevant information is important to my te compliance with my provider's instructions is critical to the success of any appropriate measures to maintain or improve my health or any condition reflected se information to my designated insurance plan for the purpose of health plan at for services rendered on my behalf. I understand a patient is responsible for all se, regardless of my insurance status. If it becomes necessary to send this for all additional charges.		

Date

Patient Signature (or Parent/Guardian if a minor)