Patient Information Sheet

Patient Information

Last Name_________________________ First Name_____________________________MI____

Address____City__________________ State___

Home Phone___________________ Cell_____________________________ Work____________

Email_________________________________ Date of Birth__________________ Gender______

Marital Status___Married ___Single ___Widowed ___Divorced ___Separated Social Security Number________

Race ___American Indian ___Asian ___Black or African American ___Native Hawaiian ___White ___Other

Ethnicity ___Cambodian ___Filipino ___Hispanic/Latino ___Non-Hispanic

Dependent?_________ If yes, Guardian's Name____

Address____ Phone____________

Responsible Party ________________________________ Address___________________________

City______________________________ State_______ Relationship to Patient ________________

Employer

Employment Status ___Employed ___Self-employed ___Retired ___On active military duty ___Unknown

Employer Name____________________________Employer Address_______________________

Employer phone___________________________ Position___________________________

Emergency Contact Information

Name________________________________ Relationship to Patient______________________

Home or Work Phone_________________________ Cell Number___________________________

Insurance

Primary Insurance Carrier______________________ Address___________________________

Insured's Name__________________________________ Relationship to Patient________________

Insured's ID Number ______________________________Group Number___________________

Preferred Method of Contact

Preferred Method of Contact ___ Phone ___Email ___Patient Portal ___Other

Do we have your permission to leave a detailed message including test results? ___Yes ___No

Phone number to leave messages__________________ Email to leave messages______________________

Signature

I verify that the above information is factual and true to the best of my knowledge. I understand that proof of insurance and/or copay, if applicable, is due at the time of service.

Patient or Legal Guardian Signature_________________________________ Date_____________

Pharmacy Information

Pharmacy Name____________________________________ Address____

Pharmacy Phone Number____________________________________

Authorization to Release Medical Information

Please check one

____ I authorize One to One to release my medical information 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 terminated by me in writing.

General Consent to Treat

I consent to treatment by One to One Physicians and staff for my healthcare, including but not limited to exams, testing, medications, and minor procedures. I acknowledge and agree no guarantees have been made to me as the results or outcome of my care. I understand that State Law requires physicians to report certain communicable diseases to the Health Department.

If at any time I have questions about my examination, diagnosis, or treatment, I will not proceed until my questions have been answered to that I am fully informed. I understand that giving the providers and nurses all relevant information is important to my proper diagnosis and treatment. I understand complete compliance with my provider's instructions is critical to the success of any treatment prescribed.

I authorize one to one Health to release my health information to my health plan or to a health and wellness provider approved by my health plan for purposes of advising me concerning appropriate measures to maintain or improve my health or any condition reflected in my records. I authorize One to One Health to release information to my designated insurance plan for the purpose of health plan administration, including receiving or making payment for services rendered on my behalf. I understand a patient is responsible for all charges incurred, subject to contract and program rules, regardless of my insurance status. If it becomes necessary to send this account to collections, the patient will be responsible for all additional charges.

____ _____________

Patient Signature (or Parent/Guardian if a minor) Date