

Today's Date: _____

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

Birth date: _____ Age: _____ Gender: [M F] Social Security no.: _____

Address: _____ City/State _____ Zip Code: _____

Phone number: _____ Other number: _____

Responsible Party (Parent or Guardian of minor-under 18 y/o or dependent child)

Guardian's Name: _____ Social Security no.: _____

Birth date: _____ Relationship to patient: _____

Address: _____ City/State _____ Zip Code: _____

Phone number: _____ Other number: _____

Employer: *or School Name (if student)* _____

Occupation: _____ Employer phone no.: _____

Full-time Part-time Unemployed Self-employed Retired Disable Military Other

Total Household Monthly/Annual Income: _____ Number of persons in household: _____

Marital Status: Single Married Divorced Separated Widowed Other Unknown

Ethnicity: American Indian Asia African American/Black Hispanic White Other Unknown

Insurance Information

Primary Insurance: _____ Insurance phone no.: _____

Policy no.: _____ Effective date: _____ Group no.: _____

Is this patient covered by insurance? Yes No

Pharmacy Name: _____ Phone no.: _____

Address: _____ City/State: _____ Zip code: _____

Referred to clinic by: Dr. (Name of Doctor) _____ Hospital _____

Family Friend Other _____

PLEASE CAREFULLY READ THE FOLLOWING AND SIGN WHERE INDICATED BELOW

I understand that health care at the FWC is provided by nurse practitioners, and advanced practice nurses, and other nursing and ancillary staff. I consent and grant permission to the employees of the FWC to provide health care to me.

I understand that I have the right to request a health care provider of my choice or to change my health care provider as well as to request a second opinion or referral.

I understand that the FWC is not a free clinic.

I further understand that regardless of my assigned healthcare coverage or insurance benefits, I am fully responsible for the total charges for services or treatment provided by the Family Wellness Center.

I currently have the following healthcare insurance: None Medicaid Medicare CHIP Other

I consent to the FWC disclosing my medical information as required by the insurer to obtain payment for my treatment.

I acknowledge that I have a copy of the FWC Notice of Privacy Practices.

Patient/Guardian signature: _____ Date: _____