PATIENT INFORMATION

FIRST NAME **MIDDLE INITIAL** **LAST NAME** **NICKNAME/AKA**

SOCIAL SECURITY NUMBER **DATE OF BIRTH** **GENDER:** ☐ FEMALE ☐ MALE ☐ OTHER

HOME ADDRESS **APT#** **ZIP CODE** **CITY**
STATE

CELL PHONE **HOME PHONE** **EMAIL**

PREFERRED PHARMACY **STREET NAME** **CITY**

PREFERRED COMMUNICTION
☐ Phone ☐ Mail

PREFERRED PHONE
☐ Home ☐ Cell

MED. INFO CONVEYED TO ME VIA
☐ Phone ☐ Mail

RACE: ☐ Am. Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Native ☐ White

ETHNICITY ☐ Hispanic/Latino ☐ Not Hispanic/Latino **PREFERRED LANGUAGE** ☐ English ☐ Spanish **INTERPERTER** ☐Yes ☐ No

MARRITAL STATUS ☐ Married ☐ Single ☐ Divorced ☐ Widowed

INSURANCE INFORMATION (do not fill out this section if you are not using insurance)

PRIMARY INSURANCE **SECONDARY INSURANCE**

Patient's Relationship to the *Primary Insurance* Policy Holder: ☐ Self ☐ Natural Child ☐ Spouse ☐ Other

POLICY HOLDER (if other than SELF) **DOB** **SOCIAL SECURITY NUMBER**

Patient's Relationship to the *Secondary Insurance* Policy Holder: ☐ Self ☐ Natural Child ☐ Spouse ☐ Other

POLICY HOLDER (if other than SELF) **DOB** **SOCIAL SECURITY NUMBER**

Patient/Responsible Party Signature: _____ **DATE:** _____

RELEASE OF INFORMATION

Would you like us to release your records to your Primary Care Physician? ☐ YES ☐ NO

PRIMARY CARE PHYSICIAN **PHONE NUMBER** **FAX NUMBER**

Would you like us to release your information or discuss your account with any other person besides yourself? ☐ YES ☐ NO

NAME **RELATIONSHIP TO PATIENT** **PHONE**

EMERGENCY CONTACT PERSON **PHONE**

WORK INJURY

WORK INJURIES CANNOT BE PAID FOR BY THE PATIENT OR PAID BY THE PATIENT'S INSURANCE*. All work injuries must be paid for by the employer to be treated. You must report your injury to your employer and have your supervisor/manager's contact information.*

ARE YOU HERE TODAY FOR A WORK-RELATED INJURY? ☐ YES ☐ NO

IF YES – LET THE RECEPTIONIST KNOW AND SHE WILL GIVE YOU A WORK INJURY FORM TO FILL OUT.

POST EXPOSURE

POST EXPOSURE CONSIST OF NEEDLESTICKS, SEXUAL EXPOSURE OR ALTERCATIONS WHERE YOU WERE EXPOSED TO SOMEONE ELSE'S BLOOD, SALIVA OR OTHER BODILY FLUIDS.

ARE YOU HERE TODAY FOR A POST EXPOSURE? ☐ YES ☐ NO

IF YES – *Do you know or do you suspect the individual source (person who's bodily fluids you were exposed to) to be positive for HIV, HEPATITIS and/or STDS OR HIGH RISK for HIV, HEPATITIS and/or STDS?* ☐ YES ☐ NO ☐ I DO NOT KNOW

Please give a brief description of how the post exposure occurred.

Patient/Responsible Party Signature: _____ **DATE:** _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Signing this form does not authorize release of written information. For the release of information as stated in the Notice of Privacy Practices, I understand that, if information is requested, I must sign a separate authorization form or check "YES" and list information for persons in which information is to be released to in the "Release of Information" section on this form. The Notice of Privacy Practices is provided to patients by Minor Emergency of Denton. If you would like a copy of The Notice of Privacy Practices, the receptionist would be happy to give you one.

I give this practice/clinic my consent to use or disclose my protected health information to carry out my treatment and/or to obtain payment from insurance companies.

I acknowledge the receipt of a copy of the currently effective Notice of Privacy Practices for Minor Emergency of Denton. A copy of this signed, dated document shall be as effective as the original.

FINANCIAL POLICY

Our office has limited access to verifying insurance benefits. Deductibles, co-pays, and co-insurance payments are due at the time of service. It is the patient's responsibility to know these amounts. All self-pay charges are due at the time of service.

By signing this form, I am accepting full responsibility for this account. I understand that any insurance estimate given by this office is not a guarantee of actually insurance payment or coverage. I also understand that I am responsible for all charges incurred for medical treatment performed upon my dependents or me.

RESPONSIBLE PARTY
_____

RELATIONSHIP TO PATIENT: □ SELF □ OTHER
_____

SIGNATURE_____ **DATE** _____