REGIONAL CLINIC The best you can be

Patient Information Form

Last Name: _____ First Name:_____

DOB:_____/_____/_____ Identify **Male / Female**

Social Security:_____/____/_____

Mailing Address:_____ City:_____ State ____ Zip_____

Cell Number: (_____)_____-_____ Alt Number: (____)_____-_____

Patient Email:_____@_____

Primary Pharmacy Name_____

Primary Care Physician_____ Phone:(____)_____-_____

Cardiologist_____ Phone:(____)_____-_____

Pulmonologist _____ Phone:(____)_____-_____

Urologist_____ Phone:(____)_____-_____

Specialist_____ Phone:(____)_____-_____

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Emergency Contact Information

Name:_____ Relationship:_____

Phone:(____)_____-_____ Alt Number:(____)_____-_____

Leave Message: Yes / No

Sharing Protected Health Information with Friends and Family

Occasionally patients may want us to discuss their conditions, prescriptions, lab work, or test results With members of their family or others. Under the Federal Health insurance Portability and Accountability Act, our staff is not allowed to discuss your private health issues unless you consent. Please indicate below the person(s) we may discuss your health information with (this may be a Family or friends) If you ever want to change this list (add or delete), you must notify us.

1._____ Phone:(____)_____-_____

2._____ Phone:(____)_____-_____

Assignment and Release;

* I hereby assign my insurance benefits to be paid directly to the physician
* I understand that I am financially responsible for all non-covered services, copays, deductible, and /or Coinsurance. I authorize and give my consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan.
* I authorize the physician to release any medical information required to process this claim

Sign:_____ Date:_____/_____/_____

Authorization For Treatment

I authorize my provider's office to contact me by telephone to remind me of my appointments.
Yes / No

* I hereby voluntarily consent to the rendering of such care, including diagnostic Procedures, photo, surgical and medical treatment including by authorized member of Regional Clinic.

Sign:_____ Date;_____/_____/_____