



CLAY-PLATTE FAMILY MEDICINE CLINIC, PC  
**PATIENT INFORMATION FORM**

*Partnering for Excellence in Health Care*

Date \_\_\_\_\_

Name First \_\_\_\_\_ M.I. \_\_\_\_\_ Last \_\_\_\_\_

Address \_\_\_\_\_ Apt. \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ E-mail \_\_\_\_\_

SSN \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex: M or F Marital Status: S M D W

Patient's Employer \_\_\_\_\_ Phone \_\_\_\_\_

Race  White  Hispanic/Latino  American Indian /Alaskan Native  Asian  
 Black /African American  Native Hawaiian /Other Pacific Islander  Other

Language Preference \_\_\_\_\_ Hearing Impaired  Yes  No Vision Impaired  Yes  No

Preferred Contact Method  Phone  Email  Mail Need Interpreter?  Yes  No Type \_\_\_\_\_

How did you hear about Clay Platte Family Medicine?

Insurance  Family Member  Friend  Print Ad  Billboard  Website  Phonebook  
 Other Specify \_\_\_\_\_

**Person Responsible for Account**

Name First \_\_\_\_\_ M.I. \_\_\_\_\_ Last \_\_\_\_\_

Address \_\_\_\_\_ Apt. \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

SSN \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Employer \_\_\_\_\_ Phone \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

**Primary Insurance**

Insurance Plan \_\_\_\_\_ Effective Date \_\_\_\_\_ Co-Pay \_\_\_\_\_

Policyholder Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Policyholder Date of Birth \_\_\_\_\_ Policyholder SSN \_\_\_\_\_

Policyholder Employer \_\_\_\_\_ Phone \_\_\_\_\_

**Secondary Insurance**

Insurance Plan \_\_\_\_\_ Effective Date \_\_\_\_\_ Co-Pay \_\_\_\_\_

Policyholder Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Policyholder Date of Birth \_\_\_\_\_ Policyholder SSN \_\_\_\_\_

Policyholder Employer \_\_\_\_\_ Phone \_\_\_\_\_

**Turn Page Over**

**Spouse/Parent/Guardian Information**

Name First \_\_\_\_\_ M.I. \_\_\_\_\_ Last \_\_\_\_\_

Address \_\_\_\_\_ Apt. \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

**Emergency Contact Information**

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

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**Privacy Information – Please read our privacy notice to understand who we may release your protected health information to as allowed by law.**

1. May we have your permission to leave messages regarding appointments or requests for your call back on an answering machine? Yes \_\_\_\_\_ No \_\_\_\_\_ Cell phone: Yes \_\_\_\_\_ No \_\_\_\_\_

2. To whom may we release protected health information? (Choose One)

\_\_\_\_\_ To **myself** only; (RPO)

\_\_\_\_\_ To myself and **anyone** else involved in my healthcare or payment for my healthcare (i.e., caregivers, family members; ) (NORES)

\_\_\_\_\_ To myself and **Only** to the following designated persons; (IRC)

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

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**Assignment of Insurance Benefits/Release of Medical Information**

I understand pre-certifications/authorizations/referrals are my responsibility.

I hereby authorize treatment deemed necessary by the above named physicians. I also authorize the release of my medical records to any insurance company with whom I have health insurance coverage or to any company to which I have applied for coverage. I request payment of medical insurance benefits to include major medical to be made directly to **CLAY PLATTE FAMILY MEDICINE** on any unpaid bills for services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

Signed \_\_\_\_\_ Parent/Guardian \_\_\_\_\_

Date \_\_\_\_\_

