

## PATIENT INFORMATION

Patient # 00 \_\_\_\_\_ Date \_\_\_\_\_

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**Patient:**

Name: \_\_\_\_\_  
(Last) (First) (MI)

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: \_\_\_\_ SS #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Marital Status: \_\_\_\_  
(MM/DD/YYYY)

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Phone: \_\_\_\_\_

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**Spouse or Responsible Parent:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ SS #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Employer: \_\_\_\_\_

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**Please List All Persons in Household:** (Use back of sheet if you need more room.)

Name: \_\_\_\_\_ SS #: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Name: \_\_\_\_\_ SS #: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Name: \_\_\_\_\_ SS #: \_\_\_\_\_ D.O.B. \_\_\_\_\_

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**Notify in Emergency:**

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

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**Insurance:**

Primary Insurance: \_\_\_\_\_ Address: \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Address: \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

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**Authorization / Signatures:**

Date: \_\_\_\_\_

I authorize payment of medical benefits to Clear Creek Family Practice for services rendered.

X \_\_\_\_\_

I authorize the release of any medical information necessary to process claims for services rendered by Clear Creek Family Practice.

X \_\_\_\_\_

I have received a copy of the privacy practices notice of Clear Creek Family Practice.

X \_\_\_\_\_

Referred by: \_\_\_\_\_