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Patient Information

Please complete this form and return it to the receptionist. If you would like assistance, please ask.

Patient Personal Information

Last Name _____ First Name _____ Middle Initial ____ Nickname _____

Date of Birth (DOB) _____ Social Security Number (SSN) _____ Male Female

Mailing Address _____ City, State, Zip _____

Home Phone _____ Cell _____ Other _____ OK to leave message? Yes No

Race (check ALL that apply): American Indian/Native Alaskan Asian Black/African American
 Native Hawaiian Other Pacific Islander White

Ethnic Category (select one): Hispanic/Latino Non-Hispanic/Latino **U.S. Veteran?** Yes No

Special needs or disability? Yes No If Yes, please explain _____

Has the patient been diagnosed with diabetes? Yes No

Employer Address & Phone _____

Emergency Contact _____ Phone _____ Relationship _____

If patient is under 18 years of age, who is the parent or legal guardian?

Name _____ Phone _____ Relationship _____

If someone other than the patient is responsible for these medical/dental bills, please complete the following fields:

Name _____ SSN _____ DOB _____

Relationship to patient: Spouse Parent Other Phone _____ Work Phone _____

Insurance Information

PRIMARY Medical Insurance Company (if uninsured, write "NONE") _____

Name of policy holder _____ Relationship to patient: Self Parent Spouse Other

Policy holder's address (if different than above) _____ DOB _____


Insurance ID/Policy # _____ Group # _____

SECONDARY or Dental Insurance Company (if applicable) _____

Name of policy holder _____ Relationship to patient: Self Parent Spouse Other

Policy holder's address (if different than above) _____ DOB _____

Insurance ID/Policy # _____ Group # _____

(over please) 

CONSENT FOR GENERAL CARE

I present myself for health care services at The Lakes Community Health Center (The Lakes) to be provided by authorized employees of the Clinic and clinical staff as may, in their professional judgment, be deemed necessary or beneficial. I realize that among those who attend patients are medical, dental, nursing and other health care personnel in training who, unless requested otherwise, may be present during patient care as part of their education. I acknowledge that no guarantees have been made to me as to the effect of such examinations or treatments on my condition.

When a health care worker is exposed to my blood or other potentially infectious materials through any eye, mouth or other mucous membrane, non-intact skin or parenteral contact, I consent to a test of my blood to screen for the presence of Hepatitis B, Hepatitis C, Human Immunodeficiency Virus (HIV) or any antibody to the HIV virus, the cause of Acquired Immunodeficiency Syndrome (AIDS). I also consent to the release of reasonable, necessary portions of my medical record to assist The Lakes in assessing potential risk related to such exposure. I authorize The Lakes to release the test results to the exposed health care worker and any health care professional responsible for evaluating the exposed health care worker. I understand that I may have the right to consent to release of my test results to myself and/or my primary care physician.

AUTHORIZATION TO RELEASE INFORMATION

I authorize The Lakes to disclose information from my medical/dental records (including transfer records) and/or my business office records to whom The Lakes believes is responsible for the payment of my bill or is involved in my care and treatment. Should any portion of my records contain information regarding drug or alcohol abuse, consent is given to release such information necessary to obtain payment of my bill from insurance companies or other funding sources as named on the Requisition Records. I revoke this consent at any future date upon written notification to The Lakes; however, I understand The Lakes may release information in good faith from the date I sign this consent until the date I may choose to revoke it. I authorize use of my medical/dental records and information for legitimate medical or scientific research purposes. Research procedures to not identify individuals by name or personal identifying characteristics.

OCCUPATIONAL HEALTH SERVICES

I consent to a physical examination/evaluation or testing to be performed by the staff of The Lakes occupational health and any affiliated sites. I understand that I can expect an explanation of findings of the physical examination and any tests performed. No treatment is expected in connection with this exam/testing as it is for evaluation purposes only. I understand that my employer or insurer who is requesting this examination may be responsible for reimbursing The Lakes or affiliated sites per company policy. Access to information from this evaluation/testing shall follow applicable statutes and regulations.

MEDICARE/MEDICAID PATIENTS

I certify the information I gave in applying for payment under Title XVIII or XIX of the Social Security Act is correct. I request payment of authorized benefits on my behalf for any services furnished me by The Lakes, including physician services, and assign such benefits to The Lakes. I authorize The Lakes to release to Medicare/Medicaid and its agents any information needed to determine these benefits or related services. I understand I am responsible for the costs of non-covered services and for the deductible, co-insurance and co-payment charges allowed under federal regulations.

X _____
Signature of Patient or Authorized Representative Date
Reason patient did not sign: _____

X I acknowledge being offered the The Lakes Notice of Privacy Practices _____(Initials)

FINANCIAL AGREEMENT

I agree to pay The Lakes for all services provided to me by The Lakes and others for whom The Lakes collects bills at the regular rates. This includes services which, for any reason, are not paid by insurance, government programs or other third party sources. I understand that any self-pay portion of my clinic bill is due upon notification. I further agree to pay reasonable attorney's fees and all costs of collection in the event my account is turned over to an attorney or collection agency.

I authorize payments be made directly to The Lakes of insurance, Medicare/Medicaid benefits or other funding sources I am entitled to as payment for services provided me. I understand professional (physician) services for radiology, lab and pathology are charged separately from my clinic bill and that I am financially responsible to those physicians for any charges for their professional services. If assignment of insurance benefits is accepted by such physicians, I authorize insurance payments be made directly to those physicians.

X I accept financial responsibility as outlined above: _____
Signature of Guarantor Date