Patient Information Care Sheet

Name_____
(Last) (First) (Middle Initial)

Home Address: _____ Apt. #:_____

City: _____ State: _____ Zip Code: _____

Day:_(_____)_____ Home Work Cell (Please Circle One)

Evening:_(_____)_____ Home Work Cell (Please Circle One)

May we leave medical information on an answering machine/voicemail? YES NO (please circle one)

May we communicate your medical information with another person? YES NO (please circle one)

If yes, with whom? Name _____Phone (_____)_____

Social Security Number: _____ Birthdate: _____

Your Employer: _____ Work Telephone: (_____)_____

Do you currently have insurance? ☐yes ☐no If yes, name of carrier: _____

Guarantor Name (if the patient is a minor or student):_____ Relationship_____

Sex: ☐Male ☐Female **Marital Status**: ☐Single ☐Partnered ☐Widowed ☐Married ☐Divorced

Preferred Language: ☐English ☐Indian ☐Russian ☐Spanish ☐Other

Ethnicity: ☐Hispanic or Latino **Race:** ☐American Indian ☐Black or African America

☐Non-Hispanic or Latino ☐Asian ☐White

☐Refuse to Report ☐Native Hawaiian ☐Hispanic ☐ Other

E-mail (For Patient Portal Signup only):_____

In Case of Emergency: First Name: _____Last Name:_____

Relationship_____Phone Number: (____)_____

Do we have your permission to contact this person regarding matters concerning your care? ☐Yes ☐No

I,_____understand that payment and/or current insurance information is required at the time of service. I assign all rights and claims for reimbursement of expenses allowable under my insurance plan and authorize payment directly to *Northwest Health Care Associates* for services and/or treatments rendered. I understand that *Northwest Health Care Associates* does not accept responsibility for collecting my insurance claims or for negotiating a settlement on disputed claims. I understand that I am responsible for charges not covered by my medical insurance plan(s). If my account exceeds 60 days without payment or arrangement, my account will be considered delinquent and can be subject to legal action and/or assignment to a collection agency.

Signed: _____ Date: _____

If you are not the patient, please specify your relationship to the patient_____