

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)

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 _____

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 (_____)

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): _____

Preferred method of confirming appointments: Patient Portal Phone Call

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 _____