Schneck Family Care
Patient Information Sheet

Patient Name:		**Date of Birth:**		Marital Status:
Address:		Sex:		Soc. Sec.#:
City:	St:	Zip:	Do we have your permission to leave information related, but not limited, to appointment, billing, negative test results on answering machine/ voicemail at (***please check box***): ☐ Home ☐ Cell ☐ Work? ☐ No	
Home Ph.#:		Cell #:	Work#:	Place of Employment:
Email Address:			Primary Language:	

RACE: ***(Please Check appropriate boxes)***
☐ AMERICAN INDIAN / ALASKA NATIVE ☐ ASIAN ☐ BLACK/AFRICAN AMERICAN ☐ NATIVE HAWAIIAN
☐ OTHER PACIFIC ISLANDER ☐ WHITE ☐ MORE THAN ONE RACE ☐ REFUSED TO REPORT

ETHNICITY: (*please check box*)
☐ HISPANIC / LATIN AMERICAN ☐ NON-HISPANIC / LATIN AMERICAN ☐ REFUSED TO REPORT

Responsible Party:		Sex:	Date of Birth:
Address:	City:	St:	Zip:
Soc. Sec.#:	Home Ph.#:	Cell#:	Work#:

Emergency Contact Name: (Outside the household) **:**

Home Ph.#:	Cell #:	Relationship:

HEALTH INSURANCE INFORMATION

PRIMARY INSURANCE		SECONDARY INSURANCE	
Carrier Name:		Carrier Name:	
Subscriber Name:		Subscriber Name:	
Date of Birth:	Soc. Sec.#:	Date of Birth:	Soc. Sec.#:
***Insurance cards, photo ID and co-payments must be presented at time of service.**		***Insurance cards, photo ID and co-payments must be presented at time of service.**	

INFORMED CONSENT REGARDING MY MEDICAL CONDITION

☐ I authorize Schneck Family Care to speak with the individual(s) listed below regarding my medical condition.	☐ I authorize Schneck Family Care to release any prescriptions, correspondence, or medication samples, in a sealed envelope, to the individual(s) listed below.	☐ I only want medical information given to myself personally.

Name: Relationship:	Name: Relationship:

GENERAL CONSENT FOR CARE: *I acknowledge that I choose to enter into care at Schneck Family Care, and hereby give my consent for such care. I understand that I may be asked for additional consent for specific procedures and/or tests.*

AUTHORIZATION & ASSIGNMENT: Please read and sign the following statement:

We will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed **NOTICE OF PRIVACY PRACTICES** to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facilities and have copies available for distribution. I acknowledge that I have received a copy of the **NOTICE OF PRIVACY PRACTICES**.

I authorize Schneck Family Care to furnish information to other physicians, insurance carriers and other related entities concerning the illness or medical treatment of my dependent or myself. I recognize and accept responsibility for payment of all medical fees regardless of any insurance I may have to assist me in this responsibility. I also hereby assign to the provider(s) all insurance payments for medical services rendered to my dependent or myself, except those services for which I have already paid prior to the filing of the insurance claim on my behalf. If for any reason the account should become delinquent, I agree to pay for all court costs, collection and legal fees, and interest due.

familycare schneck

I have read the above information.

_____
Signature of Patient or Responsible Party

_____
Date