
PATIENT INFORMATION

Legal Name: _____
(Last) (First) (Middle)

Social Security No: _____ / _____ / _____ Date of Birth: _____ / _____ / _____ Age: _____ Alias _____ Sex _____

Mailing Address: _____
(Street) (City) (State) (Zip)

Home Phone: _____ Marital Status: Single Married Divorced Widowed Other

Employer: _____ Occupation: _____ Work Phone: _____

PERSON TO CONTACT IN CASE OF EMERGENCY

Name: _____ Relationship: _____ Phone: _____

Family Physician: _____ Phone: _____

Address: _____

FAMILY INFORMATION

Spouse's Name: _____ Social Security No: _____ / _____ / _____ Date of Birth: _____ / _____ / _____

If Different
Mailing Address: _____ Home Phone: _____
(Street) (City) (State) (Zip)

Employer: _____ Occupation: _____ Work Phone: _____

IF PATIENT IS A MINOR

Father's Name: _____ Social Security No: _____ / _____ / _____ Date of Birth: _____ / _____ / _____

If Different
Mailing Address: _____ Home Phone: _____
(Street) (City) (State) (Zip)

Employer: _____ Occupation: _____ Work Phone: _____

Mother's Name: _____ Social Security No: _____ / _____ / _____ Date of Birth: _____ / _____ / _____

If Different
Mailing Address: _____ Home Phone: _____
(Street) (City) (State) (Zip)

Employer: _____ Occupation: _____ Work Phone: _____

INSURANCE INFORMATION

Copays are expected at time of service.

Copay Amount: _____

Method of Payment: Cash Check Credit Card

Primary Insurance: _____

Identification Number: _____

Group Number: _____

Subscriber: _____

Secondary Insurance: _____

Identification Number: _____

Group Number _____

Subscriber: _____

VISIT INFORMATION:

Please state briefly the reason for your visit today: _____

Work Related? Yes No Motor Vehicle accident? Yes No Other: _____

How did the injury happen? _____

When did the injury happen? _____

Where did the injury happen? _____

CONSENT FOR TREATMENT

CONSENT: The undersigned consents to any medical, surgical, or diagnostic services, which are ordered by a physician and/or rendered by MultiCare Medical Group.

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION: The undersigned authorizes MultiCare Medical Group to release any information which is required to determine benefits, eligibility, and to process claims for payments on services rendered. The undersigned authorizes all insurance payments be made payable directly to MultiCare Medical Group for any and all medical and surgical services rendered.

FINANCIAL AGREEMENT: The undersigned agrees that in consideration of services rendered he/she hereby agrees to pay for services in accordance with regular rates and terms of MultiCare Medical Group. Should the account be referred to an attorney or collection agency, the undersigned shall pay all reasonable attorney's fees and/or collection costs.

PATIENT RIGHTS/ADVANCE DIRECTIVES: The undersigned agrees that a copy of the *Patient Rights and Responsibilities* has been made available to them, in addition, the undersigned is aware that *Advance Directive* information/education material is available to them from MultiCare Medical Group.

Patient or Responsible Party Signature

Date