Quality Care Family Practice
Patient Information

Patient's Name:
Last_____First_____MI_____
Address: _____Apt____City_____State_____Zip_____
Phone: Home_____Work_____Cell_____
Birthdate: _____Sex: M____F___
E mail address:_____
Driver License: _____SS#:_____
Marital Status S __M __D ___Sep __W___
Spouse's name: _____Phone_____

Emergency contact information:
Name:_____
Address_____City_____State_____Zip_____
Phone:Home_____Work_____Cell_____
SS#_____
Relationship to patient: _____

Insurance Information *(must be completed even if we have a copy of insurance card)*
Primary Insurance_____ID#_____
Subscriber's Name_____ Birthdate_____
Sex: M__F__
Relationship to patient_____
Secondary Insurance_____ID#_____

Consent to treat a minor: I(We), being the parent(s) or guardian(s), entitled to the care, custody, and control of the above named minor, do hereby authorize and direct you to render such treatment to said minor as in your judgment is advisable. It is understood that the above named minor may occasionally appear at your office for examination and treatment, or both, unaccompanied by an adult, because of my (our) absence or unavailability. This consent will be in effect until terminated by written notice.
Initial_____

Acknowledgement of Receipt of Notice of Privacy Practices: I have read Quality Care Family Practice Notice of Privacy Practices. Initial_____

I understand I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature is as valid as the original. I understand that an additional fee may be added if my account becomes delinquent. Initial_____

My signature below is to acknowledge that I read, understand, and agree to the above statements.

Signature:_____Date:_____