

Today's Date \_\_\_\_\_  
Primary Care Provider \_\_\_\_\_



**PATIENT RECORD INFORMATION**

**Please complete each section**

**Patient Information:**

**If the Patient is a child (under age 18) please provide information on the Adult who is accompanying the child**

Patient Name: \_\_\_\_\_  
Male \_\_\_\_\_ Female \_\_\_\_\_ PatientSS# \_\_\_\_\_  
Marital Status: \_\_\_\_\_ S \_\_\_\_\_ M \_\_\_\_\_ W \_\_\_\_\_ Div \_\_\_\_\_ Sep \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Dr License # \_\_\_\_\_  
Race \_\_\_\_\_  
Ethnic Group \_\_\_\_\_  
Preferred Language \_\_\_\_\_  
Address \_\_\_\_\_  
City, Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_  
Email \_\_\_\_\_  
Preferred Contact Method: Home Cell Work \_\_\_\_\_  
Student \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_  
Place of Employment \_\_\_\_\_  
Employment Status: \_\_\_\_\_ FT \_\_\_\_\_ PT \_\_\_\_\_ Retired \_\_\_\_\_

Name: \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Birthday \_\_\_\_\_ SS# \_\_\_\_\_  
Marital Status: \_\_\_\_\_ S \_\_\_\_\_ M \_\_\_\_\_ W \_\_\_\_\_ Div \_\_\_\_\_ Sep \_\_\_\_\_  
Dr License # \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_  
Email address \_\_\_\_\_  
Address \_\_\_\_\_  
City, Zip \_\_\_\_\_  
Place of Employment \_\_\_\_\_  
Employment Status \_\_\_\_\_ FT \_\_\_\_\_ PT \_\_\_\_\_ Retired \_\_\_\_\_

**Insured's Information (Subscriber/Policy Holder)**

Name: \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Birthday \_\_\_\_\_ SS# \_\_\_\_\_  
Marital Status: \_\_\_\_\_ S \_\_\_\_\_ M \_\_\_\_\_ W \_\_\_\_\_ Div \_\_\_\_\_ Sep \_\_\_\_\_  
Dr License # \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_  
Email address \_\_\_\_\_  
Address \_\_\_\_\_  
City, Zip \_\_\_\_\_  
Place of Employment \_\_\_\_\_  
Employment Status \_\_\_\_\_ FT \_\_\_\_\_ PT \_\_\_\_\_ Retired \_\_\_\_\_

**Person(s) to Notify in Case of Emergency:**

Name \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Phone # \_\_\_\_\_  
Name \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Phone # \_\_\_\_\_

What Pharmacy do you use? \_\_\_\_\_

**Please make sure that we have a current copy of your insurance card. Thank you.**

I authorize Hillcrest Clinic Providers to furnish any information to my insurance company in order to process my claim. I grant permission to release medical records to my insurance company as necessary. I understand that I am responsible for my expenses unless assignment is accepted, and that my insurance coverage is a contract between myself and the insurance company. I understand that payment/copayment is expected at the time of service unless prior arrangements have been made. I understand that Hillcrest does not file Medicaid retroactively, except in the case of newborns and Medically Needy Spend Down. I do agree for my insurance money to go to Hillcrest Clinic Providers.

Signature \_\_\_\_\_ Date \_\_\_\_\_