POWER COUNTY FAMILY CLINIC
PATIENT INFORMATION SHEET

PATIENT INFORMATION:

Last Name ______ First Name ______ MI ______

Street Address ______ PO Box ______ City ______

State ______ Zip ______ Phone # ______ Cell # ______

Social Security ______ Birthday ______ Sex-Male ______ Female ______

Marital Status- S___ M___ W ___ D___ Drivers License # ______ State ______

EMPLOYMENT INFORMATION:

Employer ______ Status- Full Time ______ Part Time ______ Temp. ______

Street Address ______ City ______ State ______ Zip ______

Phone ______ Occupation ______

NEXT OF KIN/EMERGENCY CONTACT:

1 - Last Name ______ First Name ______ MI ______

Street Address ______ PO Box ______ City ______

State ______ Zip ______ Home # ______ Work# ______ Relationship ______

2 - Last Name ______ First Name ______ MI ______

Street Address ______ PO Box ______ City ______

State ______ Zip ______ Home # ______ Work# ______ Relationship ______

DO YOU HAVE ADVANCED DIRECTIVES? Yes ______ No ______

DO YOU HAVE A LIVING WILL? Yes ______ No ______ If so, where is it kept? ______

DO YOU HAVE MEDICAL POWER OF ATTORNEY? Yes ___ No ___ Name ______ Phone# ______

DO YOU HAVE ANY DRUG ALLERGIES? ______

DATE OF LAST TETANUS SHOT ______

GUARANTOR INFORMATION: (Person financially responsible.)

Last Name ______ First Name ______ MI ______

Street Address ______ PO Box ______ City ______

State ______ Zip ______ Phone # ______ Cell # ______

Social Security ______ Birthday ______ Relationship to patient ______

Employer ______ Phone # ______

Street Address ______ City ______ State ______ Zip ______

I acknowledge by signing below that I have received the Power County Hospital District "Notice of Privacy Practices".

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

I hereby authorize PCHD to apply for benefits on my behalf for covered services rendered by Power County Family Clinic. I request that payment from my insurance company be made directly to PCHD/Power County Family Clinic.

I certify that the information I have provided is true and correct.

Signed ______ Date ______