FALL CREEK SKIN AND HEALTH CLINIC – PATIENT INFORMATION FORM

WELCOME! Thank you for trusting us with your health care. We promise to do our very best to provide you with the finest care available. If you have any questions or concerns, please ask or give us a call, 208.359.2263.

DATE:______________________

PATIENT INFORMATION

Patient Name: First_______________________________MI________ Last________________________________

DOB:______________________ Sex: □ M □ F Marital Status: □ Single □ Married □ Divorced □ Widowed □ Separated □ Life Partner

Parent / Legal Guardian Name if patient is a minor Name________________________________ DOB________________

Address: ____Apt # ________ City____________________State__________Zip _____________

Phone: Home______________________________Cell________________________________ Work____________________________________

E-Mail____

Best Contact Method: □ Home □ Cell □ Work □ E-Mail □ Mail By checking one of the boxes for Best Contact Method, I agree to receiving correspondence from FCSH

Employment Status: □ Full-Time □ Part-Time □ Unemployed □ Student □ Disabled □ Retired Employer/School:_________________________________

Preferred Language: English________ Spanish________ Other____________________________

Do you have any communication difficulties/ special needs? Hearing Loss Interpreter Required Reading Difficulty Sight Impaired Other? Yes No

If yes, please list: ____

FINANCIALLY RESPONSIBLE PARTY

[ ] Same as Patient Information *(If different, please complete section below)*

Name: First___________________________________MI________ Last____

DOB: ______________________ Relationship: Spouse Parent Guardian Other (Please Specify): ______________________________

Address: ______________________________________Apt #___________ City____________________State__________Zip ______________

Phone: Home______________________________ Cell________________________________ Work____________________________________

Email Address ____

Employer: ____

EMERGENCY CONTACT

Name: ____ Relationship to Patient: _____________________________________

Phone: Home______________________________ Cell________________________________ Work____________________________________

Name: ____ Relationship to Patient: _____________________________________

Phone: Home______________________________ Cell________________________________ Work____________________________________

WHO CAN WE THANK FOR REFERRING YOU?

Name: ____

Continue to next page

FOR OFFICE USE ONLY:

Patient Name____________________
Patient Chart #____________________

OPTIONAL AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO OTHERS

[ ] Do Not Release Information

I authorize Fall Creek Skin and Health Clinic, PLLC and its representatives to use the additional contact information listed below to discuss or disclose information regarding any matters relating to my appointments, billing information and/or medical care. This authorization will remain in effect until I provide written notification to Fall Creek Skin and Health Clinic, PLLC of changes or update. I authorize Fall Creek Skin and Health Clinic, PLLC to use the additional contact information listed below to discuss or disclose information regarding any matters relating to my appointments, insurance, billing information, test results and/or medical care.

Name ____________________ Relationship________________ Phone________________

You may release the following information to the person named above: ◻ Appointments ◻ Billing Information ◻ Medical Care ◻ Leave Message

Name ____________________ Relationship________________ Phone ________________

You may release the following information to the person named above: ◻ Appointments ◻ Billing Information ◻ Medical Care ◻ Leave Message

If you wish to receive your health information by email, the information will be sent via encrypted email unless you expressly designate otherwise below. Sending health information by unencrypted email may pose some risk that the health information in the unencrypted email could be read by a third party over the Internet. **Initials** ____________

Please provide a copy of all Insurance Cards and a Driver's License / Photo ID

You will be asked to present your insurance card(s) at each visit so that we can confirm that all information in our files remains current.

INSURANCE INFORMATION

Primary Insurance____________________ ID# ____________________ Group#____________

Policy Holder Name:____________________ Relationship (Circle One) Self Spouse Parent Other ____________

SS#________________ Policy Holder's DOB________________

Employer____________________

Secondary Insurance____________________ ID# ____________________ Group# ____________

Policy Holder Name:____________________ Relationship (Circle One) Self Spouse Parent Other ____________

MEDICAL HISTORY

Check all illnesses which have occurred in any of your **blood relatives**:

[ ] Diabetes [ ] Heart Disease [ ] Cancer - Type:____________ [ ] Stroke [ ] Nervous Illness [ ] Kidney Disease
[ ] Bleeding Tendency [ ] High Blood Pressure [ ] Allergy [ ] Tuberculosis [ ] Other ________________

Check all illnesses which **you** have or have had in the past:

[ ] AIDS
[ ] Appendicitis
[ ] Arthritis
[ ] Asthma
[ ] Bleeding Disorders
[ ] Breast Lump
[ ] Cancer
[ ] Cataracts
[ ] Chemical Dependency
[ ] Chicken Pox
[ ] Diabetes
[ ] Emphysema
[ ] Epilepsy
[ ] Glaucoma
[ ] Heart Disease
[ ] Hepatitis
[ ] Herpes
[ ] High Cholesterol
[ ] HIV Positive
[ ] Kidney Disease
[ ] Liver Disease
[ ] Measles
[ ] Migraine Headaches
[ ] Multiple Sclerosis
[ ] Mumps
[ ] Pacemaker
[ ] Pneumonia
[ ] Polio
[ ] Prostate Problems
[ ] Rheumatic Fever
[ ] Scarlet Fever
[ ] Stroke

MEDICATION REFILL

Please contact your pharmacy for medication refills. Your Pharmacy will fax us a medication refill request which the physician will review. Refill authorizations may require 48-72 hours. Please allow sufficient time for us to process your refill request. **Initials** ____________

Pharmacy Name____________________ Address ____________________