



PATIENT INFORMATION

DATE: _____

CHART NO: _____

ACCT # _____

DOCTOR #: _____

PATIENT NAME: _____ NAME TITLE _____ <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE				
(LEGAL) LAST	FIRST	MIDDLE INITIAL		
ADDRESS: _____				
STREET	PO BOX	CITY	STATE	ZIP
HOME PHONE: () _____ CELL PHONE: _____				
MARITAL STATUS: <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED				
BIRTH DATE: _____ AGE: _____ SOC SEC NO: _____				
EMPLOYER: _____ OCCUPATION: _____ WORK PHONE: () _____ EXT: _____				
PATIENT'S ALTERNATE NAME (NICK NAMES/MAIDEN NAMES): _____				
SPOUSE'S NAME: _____ BIRTH DATE: _____ SOC SEC NO: _____				
EMPLOYER: _____ OCCUPATION: _____ WORK PHONE: _____ EXT: _____				

IF PATIENT IS A MINOR

RESPONSIBLE PARTY / BILLING INFORMATION:				
MOTHER'S NAME: _____ BIRTH DATE: _____ SOC SEC NO: _____				
ADDRESS: _____ HOME PHONE: () _____				
STREET	PO BOX	CITY/STATE/ZIP		
EMPLOYER: _____ WORK PHONE: () _____ CELL PHONE: _____				
FATHER'S NAME: _____ BIRTH DATE: _____ SOC SEC NO: _____				
ADDRESS: _____ HOME PHONE: () _____				
STREET	PO BOX	CITY/STATE/ZIP		
EMPLOYER: _____ OCCUPATION: _____				
WORK PHONE: () _____ CELL PHONE: _____				
SIBLING: _____ BIRTH DATE: _____ SIBLING: _____ BIRTH DATE: _____				
SIBLING: _____ BIRTH DATE: _____ SIBLING: _____ BIRTH DATE: _____				

NEAREST RELATIVE OR FRIEND NOT LIVING WITH YOU				
NAME: _____ RELATIONSHIP TO PATIENT: _____				
ADDRESS: _____				
STREET	PO BOX	CITY	STATE	ZIP
HOME PHONE: () _____ CELL PHONE: _____				
EMPLOYER: _____ WORK PHONE: () _____ EXT. _____				

Do you have an **ADVANCED DIRECTIVE** (Living Will or Durable Power of Attorney)? Yes No

If yes, please provide a copy for your medical record.

If no, would you like information on an **ADVANCED DIRECTIVE** Yes No

Power of Attorney _____ (_____) _____
Name Phone

Relationship to Patient _____

CONSENT FOR TREATMENT: Knowing that I (or _____) have a need for routine preventative care and/or have a condition requiring diagnosis and medical or surgical treatment, do hereby consent to the following:

- 1) All medical and surgical treatment, x-ray, laboratory, and other medical or office procedures as may be performed or prescribed by my physician, provider or clinic personnel designated. I acknowledge that no guarantees have been made to me, and I am aware that I have the right to ask my physician questions regarding any treatment or examination.
- 2) To testing for HIV (AIDS) and/or Hepatitis should a health care worker have accidental exposure to my blood or other body substances.

AUTHORIZATION FOR RELEASE OF INFORMATION AND ACKNOWLEDGMENT OF FINANCIAL RESPONSIBILITY:

- 1) I request that payment by Medicare be made either to me or the provider on any bills for services furnished to me during the effective period of this authorization, and I authorize my provider to release to the Social Security Administration or its intermediaries or carriers any information needed for this claim or any related Medicare claim.
- 2) This authorization applies to Medicaid and other insurance companies as well; however, I understand that I am financially responsible to Sioux Valley Clinic for any charges not covered by my policy.
- 3) I further authorize release of medical and/or billing information to the following individual(s):

Release to: _____ Relationship: _____

(Need one signature per year) – (Patient/Legal Guardian Signature)

PATIENT'S SIGNATURE: _____ DATE: _____

PATIENT'S SIGNATURE: _____ DATE: _____

PATIENT'S SIGNATURE: _____ DATE: _____