Willow Creek Family Medicine

ALL INFORMATION MUST BE COMPLETED BEFORE YOU ARE SEEN!!

Name_____ _____ ____ _____ **DOB:** _____

Last Name First Name Initial Nickname

Sex • M • F MF FM Other Age_____ **DOB**_____ **SSN#:** _____

Single • Married• Widowed• Divorced • Partner

Address_____

City_____ **State**_____ **Zip**_____ **Home Phone #**_____ **Cell #** _____

Guardian of Child_____**GuardianDOB:**_____

Responsible Party's Driver's License # _____ **Email Address** _____

Child's School: _____

Emergency contact: _____ **Relationship to patient:** _____

Emergency Contact Phone # _____ **Cell #:** _____ **Work #:** _____

Family/Primary Care Physician: _____ **Phone #:** _____

Other Doctors that care for you (Names & Specialties): _____

Patient's Employer: _____ **Work#:**_____

Other Family Member's seen at this office: _____

ALL INSURANCE INFORMATION HAS TO BE COMPLETED. NO EXCEPTIONS

Primary Insurance _____ **Effective Date:** _____ **Name of Policy Holder** _____

Policy Holders DOB:_____ **Relationship to patient:**_____

ID# _____**Group #**_____ **SSN#:**_____

Secondary Insurance _____ **Effective Date:** _____**Name of Policy Holder** _____

Policy holders DOB_____ **Relationship to the patient:** _____

ID#_____ **Group#**_____ **SSN#:** _____

- Pharmacy Name: _____ Phone #: _____

I give my consent for WCFM, to discuss patient's medical care and payment for medical care with the following people:

_____ _____ _____

Name / relationship /phone number name / relationship / phone number name/relationship/phone number

PATIENTS READ AND SIGN AGREEMENT

1 - I hereby give my consent for the providers of Willow Creek Family Medicine to evaluate and treat the above patient.

2 - I understand that my personal health information will be used for the purpose of treatment, payment and the coordination of health care needs of the patient.

_____Patient

Signature Date

Willow Creek Family Medicine

In the case of divorced parents or shared custody arrangements, the court specifies the healthcare responsibilities for the child and boundaries of the involved parties. If the patient is a child of divorced parents or shared custody, please answer the following questions based on the court document that specifies the child's healthcare needs.

According to the decree, which parent may consent to treatment and coordination of healthcare needs (not surgical):
_____

According to the decree, which parent may give consent for surgical procedures (invasive procedures:
_____

THIS CONSENT REMAINS IN PLACE UNTIL REVOKED IN WRITING OR CHILD IS NO LONGER A MINOR

Who may bring the child in for treatment or follow-up other than the legal parent?

1. **Name: _____ Relationship to patient: _____**
   Phone#_____Address:_____
2. **Name: _____ Relationship to patient: _____**
   Phone#_____Address:_____
3. **Name: _____ Relationship to patient: _____**
   Phone#_____Address:_____

Guardian's Name _____

Soc.Sec.#_____Date of Birth _____

RelationshiptoPatient_____

HomePhone#_____Cell#_____Address_____

Responsible Party's Driver's License # _____City_____ State_____

Zip_____ Email Address _____

1st Guardian's Employer _____

Occupation (indicate if student) _____ Business

Phone#_____

2nd Guardian's Name _____

Soc.Sec.#_____Date of Birth _____

RelationshiptoPatient_____

HomePhone#_____Cell#_____Address_____

Responsible Party's Driver's License # _____City_____ State_____

Zip_____ Email Address _____

2nd Guardian's Employer _____

Occupation (indicate if student) _____

BusinessPhone#_____

_____ _____

Patient Signature/Parent Signature Date