Consent for Treatment

I authorize and consent to the rendering of medical care, including diagnostic procedures and medical treatment by authorized members of Eureka Springs Family Clinic as many in their professional judgment be necessary for the below named patient. I acknowledge that no guarantees have been made as to the effect of such examinations or treatment.

Assignment of Insurance Benefits

Patient-Physician Agreement: I, the undersigned, authorize Eureka Springs Family Clinic to release any information acquired in the course of my examination or treatment to my insurance company(s) or another physician. I, recognizing that the medical insurance I possess may not completely cover the fee(s) for professional services rendered me; hereby agree that I am responsible for said fee(s). I authorize payment directly to me for their services. A photocopy hereof shall be valid as the original. I am aware that I may inquire of my physician the fee(s) for any professional services required and/or rendered.

Authorization to Release Information

I authorize Eureka Springs Family Clinic to release any information requested by the insurance company necessary to collect benefits under any policy we make claim against for services on this or a related date of service.

Guarantee of Payment

I understand that office visits are to be paid for at the time of service unless other arrangements have been made. I understand that I am responsible for the balance not covered by insurance. I understand that Eureka Springs Family Clinic does not accept any insurance policy assignment as a guarantee of full payment.

Patient Signature:
X __________________________________________

(Patient or Parent/Guardian if under 18 years of age)

_______________________________________________

Relationship of Guardian

_____________________

Date
**PATIENT INFORMATION**

**SOC SEC #:** ______________-____________-_______________

**Name:** ________________________________________________

<table>
<thead>
<tr>
<th>Last</th>
<th>First</th>
<th>Mid Initial</th>
</tr>
</thead>
</table>

**Address:** ______________________________________________

**City:** __________________________________________________

**State:** ___________________ **Zip Code:** ________________

**Home Phone:** _____________________________

**Work Phone:** ___________________ Ext:_______

**Cell Phone:** _____________________________

**Date of Birth: ____-____-_____** **Age:** _____yrs

**Employer:** ________________________________

**SEX:** □ Male  □ Female

**Work Address:** __________________________________________

| City: _______________ State: ____ Zip: ______ |

**MARITAL STATUS:** □ Married  □ Single  □ Divorced

□ Partner  □ Widowed  □ Separated

**Occupation:** ________________________________

**Email:** _________________________________@_________

**PRIMARY CARE PHYSICIAN:** _____________________________

---

**REFERRAL**

Who referred you to our clinic? *(PLEASE CHECK BOX)*

□ Washington Regional Medical Center  □ Community or Company Health Fair  □ Referred by a Physician:___________________________

□ Newspaper or Magazine  □ Treated by Physician in hospital  □ Employer

□ Recommended by friend or family member  □ Internet  □ Insurance Plan Directory

□ Drove by Location of Clinic  □ Phone Directory (Yellow pages)  □ Return Patient/ Not Applicable

□ Other: ________________________________

---

**SPOUSE/PARENT INFORMATION**

**Spouse/Parent Name:** __________________________________________

**Cell:** ________________________________________________

**Employer:** _____________________________________________

**Work:** ___________________ Ext: _____________

**Work Address:** _________________________________________

**Spouse/Parent SEX:** □ Male  □ Female

| City: __________________ State: ______ Zip: __________ |

**Spouse/Parent Date of Birth:** _____/_____/_____

**Occupation:** ________________________________

**Social Sec. #:** __________-_______-___________

---

**EMERGENCY CONTACT INFORMATION**

**Emergency contact:** __________________________________________

**Cell Phone:** ________________________________

**Address:** _____________________________________________

**Home Phone:** ________________________________

| City: _______________ State: _____ Zip: __________ |

**Relationship to Patient:** _____________________________
PRIMARY INSURANCE

Patient’s Relationship to **Main Policy Holder**: ☐ Myself  ☐ Spouse  ☐ Child  ☐ OTHER: ______________________

Name of Insurance Company: ____________________________________________________________

Insurance Company Address: ____________________________________________________________

City: ___________________________  State: ___________________________  Zip: ___________________

ID# ___________________________  Group # ___________________________

Insurance Company’s Phone Number: ______________________________________________________

Main Holder’s Name: ________________________________  Main Holder’s Date of Birth: ___/___/____

Main Holder’s Address: ________________________________  Main Holder’s Soc Sec#: _______-______-______

City: ________________________________

State: ________________  Zip: ________________

SECONDARY INSURANCE

Patient’s Relationship to **Main Policy Holder**: ☐ Myself  ☐ Spouse  ☐ Child  ☐ OTHER: ______________________

Name of Insurance Company: ____________________________________________________________

Insurance Company Address: ____________________________________________________________

City: ___________________________  State: ___________________________  Zip: ___________________

ID# ___________________________  Group # ___________________________

Insurance Company’s Phone Number: ______________________________________________________

Main Holder’s Name: ________________________________  Main Holder’s Date of Birth: ___/___/____

Main Holder’s Address: ________________________________  Main Holder’s Soc Sec#: _______-______-______

City: ________________________________

State: ________________  Zip: ________________
GENERAL INFORMATION
Who is responsible for Payment?:  □ Myself  □ Other: __________________________ (FILL OUT BELOW)

Responsponsible Party Name: __________________________    Responsible Party DOB: _____/_____/_____

Relationship to Patient:  □ Self  □ Spouse  □ Child  □ OTHER    SS# __________ - _____ - __________

Address: ____________________________________________ Phone#:___________

Have you ever been seen as patient at one of our Washington Regional Medical System Clinics?  □ Yes  □ No
If Yes, When?:_________/_________/______ Where?:______________________________________________

RELEASE OF INFORMATION (spouse, children, parents, etc)
Who may we discuss your information with? For example: Medical issues/care, results, billing, etc.

Name: __________________________________________   Relation to Patient: __________________________
Name: __________________________________________   Relation to Patient: __________________________
Name: __________________________________________   Relation to Patient: __________________________

Preferred Language:  □ English  □ Spanish  □ Marshallese  □ Arabic  □ DECLINE  OTHER: __________________

Race:  □ White  □ African American  □ Asian  □ Native Hawaiian/Other Pacific Islander
 □ Native American Indian/ Alaskan  □ Hispanic  □ Unknown  □ DECLINE

Ethnicity (Origin):  □ Not Hispanic or Latino  □ Hispanic or Latino  □ Unknown  □ DECLINE

Preferred Communication Method:  □ Print  □ Save to Flash Drive  □ DECLINE

Wellness Reminders:  □ Mail  □ Cell Phone  □ Home phone  □ Work Phone  □ DECLINE

Preferred Pharmacy: __________________________ LOCATION: __________________________

I authorize release of any medical information necessary to process my claim to all my insurance companies. I authorize direct payment of medical benefits to the provider. I permit a copy of this authorization to be used in the place of the original. I consent for my photo to be taken. I understand that I am responsible for any amount not covered by insurance. I permit the faxing and electronic transmission of medical information to other health care providers, attorneys, or insurance companies involved in my care. I give my permission for messages to be left on my answering machine or sent by email. I authorize WRMC operators in their role as an answering service to release my protected health information utilizing the pager system or text messaging. I, the undersigned, authorize and consent to the rendering of medical care, including diagnostic procedures, and medical treatment by authorized members of Washington Regional Medical System or their designees, as may in their professional judgment be necessary for the above named patient. I acknowledge that no guarantees have been made as to the effect of such examinations or treatment. I have received a copy of the Notice of Privacy Practices of the clinic. I permit this facility to obtain my medication history electronically.

X___________________________________________________ Date: _________/__________/________
Signature (Patient or Parent/Guardian if minor)
Please fill out the following information:

Patient Name: _________________________________________   DOB: ______________________

Please list all your medical problems or anything you regularly see a doctor for:

__________________________________________  _______________________________________

__________________________________________  _______________________________________

__________________________________________  _______________________________________  

Please list all medications: prescriptions, over the counter, vitamins/herbs, that you’re currently are taking.

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Dosage</th>
<th>How many times a day do you take?</th>
<th>for what medical problem/condition do you take this medication?</th>
</tr>
</thead>
<tbody>
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</table>

Please list any allergies (medical, x-ray dyes, or non-medical) that you have and what reaction you have to these.

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

Please list all surgeries and the date of the surgeries:

________________________________________________________________________________________

________________________________________________________________________________________

List any medical problems you’ve had in the past:

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________
List any hospitalizations, reason, and dates:


FAMILY HISTORY of any of the following:

<table>
<thead>
<tr>
<th></th>
<th>Father</th>
<th>Mother</th>
<th>Sibling</th>
<th>Grandparent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Bleeding Disorder</td>
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</tr>
<tr>
<td>Cancer</td>
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<tr>
<td>Diabetes</td>
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<tr>
<td>Epilepsy</td>
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</tr>
<tr>
<td>Heart Disease</td>
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<tr>
<td>High Blood Pressure</td>
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<td></td>
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<tr>
<td>High Cholesterol</td>
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<td></td>
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<tr>
<td>Kidney Disease</td>
<td></td>
<td></td>
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<tr>
<td>Mental Illness</td>
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<tr>
<td>Osteoporosis</td>
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<tr>
<td>Stroke</td>
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<tr>
<td>Thyroid Disease</td>
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<tr>
<td>Other</td>
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</tbody>
</table>

SOCIAL HISTORY:
Do you use or have you ever used tobacco?  No  Yes, how much? ________________
If quit, when? _______________________

Do you use or have you ever used alcohol?  No  Yes
How often?  Never  Rarely  Occasionally Weekends  Daily

<table>
<thead>
<tr>
<th>Have you had?</th>
<th>When?</th>
<th>Have you had?</th>
<th>When</th>
<th>Have you had?</th>
<th>When</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tetanus Vaccine</td>
<td></td>
<td>Colonoscopy</td>
<td></td>
<td>Bone Density</td>
<td></td>
</tr>
<tr>
<td>Flu Vaccine</td>
<td></td>
<td>PSA test</td>
<td></td>
<td>Mammography</td>
<td></td>
</tr>
<tr>
<td>Pneumonia Vaccine</td>
<td></td>
<td></td>
<td></td>
<td>Pap Smear</td>
<td></td>
</tr>
</tbody>
</table>