

ROLLING PLAINS RURAL HEALTH CLINIC

DATE: _____

Patients Name: _____ Age: _____ Gender: M / F

SSN: _____ Date of Birth: _____ DL#: _____

Physical Address: _____
City State Zip Code

Mailing Address: _____
City State Zip Code

Telephone: Home #: _____ Work #: _____ Cell #: _____

Employer Name/Address/Phone#: _____

Names of all family members living in the household: _____

Emergency Contact – Name & Phone #: _____

PRIMARY CARD HOLDER'S INSURANCE INFORMATION

Insurance Name: _____

Insured Name: _____ Date of Birth: _____

ID#: _____ Group/Policy #: _____

SSN of Insured: _____

SECONDARY INSURANCE INFORMATION

Insurance Name: _____

Insured Name: _____ Date of Birth: _____

ID#: _____ Group/Policy #: _____

Employer Name/Address/Phone#: _____
(If different from above)

RESPONSIBLE PARTY INFORMATION
(If different from Patient)

Name: _____
First MI Last

Mailing Address: _____
City State Zip Code

Gender: M / F Date of Birth: _____ Marital Status: _____

Employer Name/Address/Phone#: _____

SPOUSE/OTHER PARENT INFORMATION

Name: _____

Date of Birth: _____ SSN: _____

Employer Name/Address/Phone#: _____

_____ I CONSENT TO HAVE BLOOD DRAWN IN THE EVENT OF A BODY FLUID EXPOSURE WHILE IN ROLLING PLAINS RURAL HEALTH CLINIC OR PHYSICIANS OFFICE.

_____ I HAVE BEEN NOTIFIED OF MY HIPPA PRIVACY RIGHTS. I AM AWARE THAT I MAY REQUEST A COPY OF THIS POLICY.

_____ I CONSENT TO BE TREATED BY ROLLING PLAINS RURAL HEALTH CLINIC/PHYSICIANS OFFICE

_____ I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO ROLLING PLAINS RURAL HEALTH CLINIC/PHYSICIANS OFFICE

Our office will file insurance for all reimbursement services, to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductibles, co-pay, and non covered service amounts. See our complete financial policy for details.

Signature of Patient or Responsible Party: _____

Date: _____