Today's Date _____

Patient Information

Patient Full Legal Name _____ Birth Date _____

Marital Status: _____ Sex M F SSN _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Work Phone _____ Preferred Language

Employer _____ City _____ State_____ Zip _____

Email Address_____Check here if request access to portal_____

Race/Ethnicity_____Decline to answer_____

Responsible Party/Subscriber

Guarantor/Responsible Party _____ Birth Date _____

Relationship to patient _____ SSN _____

Address _____ City _____ State _____ Zip _____

Emergency Contact

Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Insurance

Primary Insurance _____

ID/Member # _____ Group #_____

Secondary Insurance _____

ID/Member # _____ Group #_____

Present insurance cards and photo I.D.

Medicare Patients: Please contact Medicare and advise them of your secondary to ensure claims are forwarded and paid, otherwise, you may be responsible for any balance due.

Office Policies & Procedures

I have read the **Office Policies and Procedures** and understand and agree to all policies.

Insurance Release

I authorize release of medical information for my insurance claims, and authorize payment of insurance benefits to Dr. Wells and all providers of Tucson Family Care.

Consent to Treat

By signing this form, I consent to treatment by Dr. Wells and/or her Nurse Practitioners.

Receipt of Privacy Practices

I acknowledge I have received a copy, or one was made available for my review, of the Notice of Privacy Practice for Tucson Family Care. TFC reserves the right to modify the privacy practices outlined in this notice.

Authorization for Voicemail Yes _____ or No _____

I authorize TFC's Physician and/or staff to leave detailed messages specific to my medical care, including test results, on the phone number(s) provided below. I understand that once a voicemail exists it is no longer covered under the HIPAA and therefore is not protected from unauthorized access.

Primary Contact Number _____

Secondary Contact Number _____

Authorization to Release Information

I authorize Tucson Family Care to release and communicate my healthcare information to the following:

Name of Person _____ Relationship _____ Phone number_____

Name of Person _____ Relationship _____ Phone number_____

By signing below, I acknowledge that I have read and understand these policies.

PRINTED NAME _____

SIGNATURE _____ **DATE**_____

(Parent/Guardian signature required for minors)

Office Use Only:

Patient Information sheet reviewed, insurance cards received and verified by _____

Policy and Procedures given to patient _____ **Date** _____