**Patient Information:**

* Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Gender: [ ] Male [ ] Female [ ] Other
* Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Appointment Information:**

* Appointment Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Appointment Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Appointment Department/Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Referring Physician (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reason for Visit:**

* New Patient
* Follow-up
* Consultation
* Procedure
* Test/Imaging
* Other (Specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History:**

Please check all that apply or provide additional information as necessary.

* Allergies (list): \_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Current Medications (list): \_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Past Medical Conditions (list): \_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Surgical History (list): \_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Family Medical History: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Symptoms/Concerns:**

* Briefly describe the reason for your visit and any specific symptoms or concerns:

**Insurance Information:**

* **Primary Insurance Provider:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Policy/Member ID:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Group Number (if applicable):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Secondary Insurance Provider (if applicable):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Policy/Member ID:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Group Number (if applicable):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent and Authorization:**

I hereby authorize the hospital to administer necessary medical care and treatment as deemed appropriate by the healthcare providers.

* I consent to the use and disclosure of my health information for treatment, payment, and healthcare operations.
* I understand that I am financially responsible for any charges not covered by insurance.

**Patient's Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Privacy Notice:**

By signing this form, you acknowledge receipt of the Notice of Privacy Practices.

**Clinic Use Only:**

* **Patient ID:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Provider:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Next Appointment (if applicable):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_