



PATIENT INFORMATION

Patient Name	SS#
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Home Address _____ Phone No.: _____

_____ Work Phone: _____

Birthdate: _____ Age: _____ Race: _____ Circle one: Male/Female Cell Phone: _____

E-mail address: _____

Patient's Employer or School: _____

Employer's Address: _____

Employment: Full Time: _____ Part Time: _____ Retired: _____ Unemployed: _____

Spouse/Parent: _____ Spouse/Parent Birthdate: _____

Spouse/Parent Employer: _____

Employer's Address: _____

Spouse/Parent SSN: _____

Emergency Contact: 1. _____ Phone No.: _____

2. _____ Phone No.: _____

PERMISSION TO DISCLOSE HEALTH INFORMATION

I give FamilyCare HealthCenter permission to leave my lab results, medication requests, test results, appointment information, etc. on my voicemail and/or answering machine at the following phone number(s) listed above:

I also give FamilyCare HealthCenter permission to leave any of my information with the following people in case I can't be reached.

1. Name: _____ Phone No.: _____

2. Name: _____ Phone No.: _____

I understand this permission may be taken back or changed in writing although the change will not affect previous permissions. By signing this I am saying I fully understand and agree to these terms.

I don't want to give permission at this time.

Signature of Patient

Date