PATIENT INFORMATION (Please Print) Today's Date____/____/____

Name _____ SS # _____
Last First M.I.

Mailing Address _____ County_____
Address City State Zip

Home Phone _____ Cell Phone_____ Work Phone _____
Area Code Area Code Area Code

Employer_____

Date of Birth ___/____/___ Age _____ Marital Status _____ Race_____

Spouse's Name _____ Date of Birth ___/____/___ SS # _____

Spouses Employer_____

Emergency Contact Person_____ Number _____
Area Code

Fathers Name (if patient is a child)_____ Date of Birth___/____/___

Mothers Name (if patient is a child)_____ Date of Birth___/____/___

PARENT OR RESPONSIBLE PARTY (if different from patient)

Name _____ SS # _____
Last First M.I.

Address_____
City State Zip

Home Phone_____ Work Phone_____
Area Code Area Code

INSURANCE INFORMATION (Please present card at time of check in)

Primary Insurance Name_____ Secondary Insurance Name_____

Ins. Address_____ Ins. Address_____

Name of Insured_____ Name of Insured_____

Insured's ID#_____ Insured's ID #_____

Group #_____ Group #_____

Policy Holder's Name_____ Policy Holder's Name_____

I authorize the release of medical information to my primary care of referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient or Responsible Party Signature_____ **Date**____/____/____

I give the Providers and Staff of the Faulkton Area Medical Center, permission to provide verbal or written medical information to the people listed below:

Name:_____ Relationship_____
Name:_____ Relationship_____
Name:_____ Relationship_____

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance o your prior Consent. Faulkton Area Medical Center provides this form to Comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA)

WRITTEN ACKNOWLEDGEMENT of receipt of Faulkton Area Medical Center's Notice of Privacy Practices.

_____ _____
Signature of Patient Date