Baptist Health Family Clinic - Cabot

New Patient Information

Full Name:			Social Security Number:	
Date of Birth:	Age:		Sex:	
Address:	City:		State:	Zip:
Race:	Language:	Ethnicity:	Marital Status:	Smoker: Y N
Phone:	Cell:	Email:		
Pharmacy:		Previous Physician:		
Employer:		Work Phone:		

Spouse/Parent Information

Name:			Relationship:	
Social Security Number:		Date of Birth:	Phone:	
Address:	City:		State:	Zip:
Employer:		Work Phone:		

Additional Guardian/Guarantor Information

Name:			Relationship:	
Social Security Number:		Date of Birth:	Phone:	
Address:	City:		State:	Zip:
Employer:		Work Phone:		

Emergency Contact

Name:		Relationship:	
Phone:		Cell:	

Insurance Information

WE WILL NEED A COPY OF YOUR INSURANCE CARD(S) AND DRIVERS LICENSE FOR OUR FILES

Authorization to Treat My Child (if applicable)

List below any persons that you give permission to accompany your child for medical treatment (other than parent or guardian):

This includes immunizations, blood draws, in office testing and shots for treatment.

Name	Relationship to You	Telephone Number
_____	_____	_____
_____	_____	_____

Authorization, Consent and Acknowledgment

I hereby authorize my insurance benefits to be paid directly to Baptist Health Family Clinic. I consent to the use or disclosure of my protected health information by Baptist Health Family Clinic for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of Baptist Health Family Clinic. I have the right to revoke this consent in writing at any time, except to the extent that Baptist Health Family Clinic has taken action in reliance on this consent. The Notice of Privacy Practices for Baptist Health Family Clinic has been provided to me.

_____ _____

Signature of Patient or Guardian Date