DATE: ______________

Family Care Medical Group, P.C. / Community Medical Center

BOLD FIELDS ARE REQUIRED

Legal Name: ______________ Chosen/Used Name: ______________ **DOB:** ______________

Legal Gender Marker: M/F Gender Identity: ______________ Sexual Orientation: ______________

Pronoun: ______________ Student ID #: ______________ Email: ______________

Wells Address: ______________ City/State: ______________ Zip: ______________

Home Address: ______________ **City/State:** ______________ **Zip:** ______________

Home Phone: ______________ and/or **Cell Phone:** ______________

Emergency Contact/Relationship: ______________

Emergency Contact Phone #: ______________

IF THE PATIENT IS A MINOR (UNDER 18), COMPLETE THIS SECTION

Father's Name: ______________ DOB: ______________ Phone: ______________

Mother's Name: ______________ DOB: ______________ Phone: ______________

Legal Guardian Name: ______________ DOB: ______________ Phone: ______________

INSURANCE INFORMATION

Insurance Company (parent/guardian insurance): ______________

Subscriber Name: ______________ ID#: ______________ DOB: ______________

HIPAA DOCUMENTATION

PLEASE ANSWER ALL QUESTIONS BELOW AND SIGN/DATE ALL 3 LINES

I acknowledge that I have been given the opportunity to read and/or receive a copy of Family Care Medical Group's Privacy Notice (Located in the waiting room and at FCMG.org) **YES** **NO**

Leave appointment message on:			**Leave other medical info on:**		
Answering Machine?	**YES**	**NO**	Answering Machine?	**YES**	**NO**
Cell Phone?	**YES**	**NO**	Cell Phone?	**YES**	**NO**
Email?	**YES**	**NO**	Email?	**YES**	**NO**

Person(s) authorized to discuss your personal medical information:				What can be discussed?	
Contact Name	**Relationship**	**Phone**	**Cell Phone**	**Appt Info**	**Medical Info**
				YES	**YES**
				YES	**YES**
				YES	**YES**

____
Initials

** I consent to have the practice use and disclose my protected health information for payment, treatment and health care operations purposes, and for such other purposes that are permitted under HIPPA or other federal or state law without my written authorization.

____
Initials

** I authorize the payment of medical benefits to above stated physician or supplier for services rendered.

____
Initials

** I authorize the use and disclosure of my protected health information to the Wells College Dean of students and covid compliance officer for payment of services and for emergency/testing purposes.

Signature: ______________ **Date:** ______________