# Fireweed Health Care - Patient Demographics

Name _____ Date _____

DOB _____ SSN _____

Daytime phone # _____ Alternate phone # _____

*** Please indicate which phone number(s) we may use to contact you during business hours for medical reasons such as random UA requests, pill counts, prescription issues, etc. by circling and initialing one or both of the above numbers. As a patient of FHC, you agree to be available for random UA's, pill counts, etc., at any time, on any day, during regular business hours. I understand and agree to this policy: **Initial:** _____ Email address: _____

Physical Address _____

_____

Is this also your mailing address? Yes No

If no, mailing address is: _____

**EMERGENCY CONTACT INFORMATION**

1. Name _____ Relationship _____

Phone _____

2. Name _____ Relationship _____

Phone _____

**CONSENT FOR SHARING OF MEDICAL AND/OR NON-MEDICAL INFORMATION**

Is there anyone you authorize the staff of Fireweed Health Care to speak with regarding your care at Fireweed Health Care? Yes No

If yes, please provide their name, relationship to you and phone #:

1. Name _____ Relationship _____

Phone _____ Medical info ok? Yes No **Non-medical only?** Yes

2. Name _____ Relationship _____

Phone _____ Medical info ok? Yes No **Non-medical only?** Yes

**INSURANCE**

Primary Insurance Carrier _____

Policy ID # _____

Secondary Insurance Carrier _____

Policy ID # _____