Fireweed Health Care - Patient Demographics

Name _____ Date _____

DOB _____ SSN _____

Daytime phone # _____ Alternate phone # _____

***As a patient of FHC, you agree to be available by phone 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:** _____

How would you like to receive your appointment reminders? (check as many options as desired)

▢ Email ▢ Text ▢ Phone

Email address _____

Physical address _____

Is this also your mailing address? ▢ Yes ▢ No

If no, mailing address is _____

Referring provider _____

Primary care provider/clinic _____

EMERGENCY CONTACT INFORMATION

1. Name _____ Relationship _____

Phone _____

1. 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 specify:

1. Name _____ Relationship _____

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

2. Name _____ Relationship _____

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

INSURANCE

Primary insurance carrier _____

Policy ID # _____

Secondary insurance carrier _____

Policy ID # _____