# 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 # ____________________________________________