FCCR
Family Care Clinic

Patient Demographic Form

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Date: _____

Patient's Name: _____ **Date of Birth**: _____ **Gender**: Male or Female

Address: _____ **City, State, Zip**: _____

Contact Number: (___)_____ **Secondary Phone** :(___)_____

E-Mail Address: _____ **Social Security #**: _____

Marital Status: Single Married Divorced Widowed

Race: AM Indian African American Native Hawaiian/Pacific Islander Asian White Hispanic Declined

Mother's Maiden Name: _____

Emergency Contact: _____ (___)_____
Name Relationship

Guarantor Information:

Name: _____ **Relationship**: _____

Address: _____ **City, State, Zip**: _____

Date of Birth: _____ **Social Security #**: _____

Contact Number: (___)_____

Employer & Address Information: _____

Occupation: _____

Please Note:
Our office will file primary & secondary insurance carriers for all reimbursable services.
Please remember that you are responsible for all **DEDUCTIBLES, CO-PAYS, & NON-COVERED SERVICE AMOUNTS**.

General Consent:
I, _____ (Initial Here) am voluntarily seeking medical treatment. I consent to examination by the Physician, Nurse Practitioner, Nurse, and other healthcare professionals at Family Care Clinic of Ripley. I also consent any medical procedures, x-rays, lab test(s), or other health care services ordered by my healthcare team. I understand that I may refuse specific treatments or procedures by informing my healthcare team.

Release of Information:
I authorize this clinic to release any information necessary to process my claim.
Assignments of Insurance Benefits and Acceptance of Financial Responsibility:
I authorize payment directly to the clinic. I understand and agree that if any part of my account is not paid by the insurance, I am financially responsible.

_____ _____

Patient's Signature or Authorized Person to Sign **Date**