



# Family Health Center Personal Information Sheet

Provider: _____
Appointment time: _____
PW to Billing: _____
Pt to Waiting Room: _____

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
                     First                      Middle                      Last

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Primary Phone \_\_\_\_\_ Alt Phone \_\_\_\_\_

Gender:  Male       Female      Social Security # \_\_\_\_\_

Emergency Contact \_\_\_\_\_ How Related \_\_\_\_\_

Primary Phone \_\_\_\_\_ Alt Phone \_\_\_\_\_

For Children Under 18: Mother's Name \_\_\_\_\_ Father's Name \_\_\_\_\_

Veteran: \_\_\_\_\_ Student: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Referral Source: \_\_\_\_\_

Race (check one)

- Asian       Native Hawaiian       Other Pacific Islander       Multirace  
 Black/African American (not Hispanic/Latino)       American Indian/Alaskan Native  
 White (not Hispanic/Latino)       Hispanic or Latino (all races)       Refused/Unknown

### Insurance Information

Do you have Medicaid or MC+?       Yes       No      Do you have Medicare Part B?       Yes       No

Medicaid or MC+ ID \_\_\_\_\_ Medicare ID \_\_\_\_\_

Do you have Private Insurance?       Yes       No      Do you have Secondary Insurance?       Yes       No

Ins Company \_\_\_\_\_ ID \_\_\_\_\_ Employer \_\_\_\_\_

### Verification and Consent to Treatment

I verify that the above information is true to the best of my knowledge. I agree to notify the Family Health Center of any change in the information stated above.

I hereby consent to the above named patient, whose name appears on this form, receiving medical care considered advisable by the attending medical professional of the Family Health Center.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

FHC Policy states 3 missed appointments not rescheduled within 4 hours or more of appointment time will result in same day status. Six missed appointments not rescheduled within a year will result in review for discharge from the FHC practice.

**1001 West Worley  
Columbia, MO 65203**

**Family Health Center  
307 S. Broadway St.  
Salisbury, MO 65281**

**225 W. Hayden St, Ste 200  
Marceline, MO 64658**

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Patient Name

The undersigned does hereby authorize the release of medical information to the patient's insurance carrier(s), Medicare, Medicaid, or a third party payer as needed to determine benefits payable for services rendered. I authorize the release of medical and financial information necessary for the Family Health Center to obtain needed services and supplies for the above named patient and/or to arrange for specialty or follow-up services.

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Signature of Patient

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Signature of Parent/Guardian

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Date

**STATEMENT ON FILE**

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Patient Name

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HIC Number

I request that payment of authorized Medicare benefits be made wither to me or on my behalf to the Family Health Center for any services furnished to me by providers of the Family Health Center. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

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Signature of Patient

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Signature of Parent/Guardian

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Date