



# Family Health Center Personal Information Sheet

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

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

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Primary Phone (\_\_\_\_) \_\_\_\_\_ Alt Phone (\_\_\_\_) \_\_\_\_\_

Gender: (M/F)                      Marital Status: (S, M, W, D)                      Veteran: (Y/N)

Social Security # \_\_\_\_\_

Housing (circle one): Own      Rent      Public Assisted      Friend      Migrant      Homeless

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

**Ethnicity (check one):**     Hispanic/Latino     Non-Hispanic/Non-Latino

**Race (check one):**

- Asian       Native Hawaiian       Other Pacific Islander       White  
 Black/African American       American Indian/Alaskan Native       More than one race  
 Refused/Unknown

**How did you hear about our clinic?** (TV, phone book, friend, family, insurance company, other \_\_\_\_\_)

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

Primary Phone (\_\_\_\_) \_\_\_\_\_ Alt Phone \_\_\_\_\_

## 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

**See Back Of This Page For Insurance Information**

Services Provided on a Non-Discriminatory Basis

# Family Health Center

1001 West Worley  
Columbia, MO 65203

307 S. Broadway St.  
Salisbury, MO 65281

225 W Hayden St. Ste 200  
Marceline, MO 64658

\_\_\_\_\_  
Patient Name

## 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 \_\_\_\_\_

Guarantor Name \_\_\_\_\_ Guarantor Relationship to Patient \_\_\_\_\_

Guarantor DOB \_\_\_\_\_ Guarantor SSN \_\_\_\_\_

**Please provide a copy of the insurance card to the front office. Please notify FHC of any changes to insurance.**

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.

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

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

\_\_\_\_\_  
Date

## STATEMENT ON FILE

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.

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

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

\_\_\_\_\_  
Date

Services Provided on a Non-Discriminatory Basis