Date: ________________________

Chart No: ____________________

PATIENT INFORMATION

PATIENT NAME: ______________________________________ Name Title _______ ☐ Female ☐ Male
(Legal) Last First MI

Address: ____
Street PO Box City State Zip

Home Phone: ( ) ______________________ Cell Phone: ( ) ______________________

E-Mail Address: ______________________ ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

Birth Date: ______________ Age: ________ Soc Sec No: ______________________

Race: ______________ Ethnicity: ______________ Language: ______________

Employer: ______________ Occupation: ______________ Work Phone: ( ) ______________

Patient's Alternate Name (Nick Name/Maiden Name): ______________________________

Spouse's Name: ______________________ Birth Date: __________ Soc Sec No: ______________

Employer: ______________ Occupation: ______________ Work Phone: ( ) ______________

IF PATIENT IS A MINOR - Responsible Party/Billing Information:

Mother's Name: ______________________ Birth Date: __________ Soc Sec No: ______________

Address: ______________________________________ Home Phone: ( ) __________
Street PO Box City/State/ Zip

Employer: ______________ Occupation: ______________ Work Phone: ( ) ______________

Father's Name: ______________________ Birth Date: __________ Soc Sec No: ______________

Address: ______________________________________ Home Phone: ( ) __________
Street PO Box City/State/ Zip

Employer: ______________ Occupation: ______________ Work Phone: ( ) ______________

EMERGENCY CONTACT:

Name: ______________________________________ Relationship: ______________________

Address: ____
Street PO Box City State Zip

Home Phone: ( ) ______________________ Cell Phone: ( ) ______________________

Employer: ______________________________ Work Phone: ( ) ______________________

INSURANCE INFORMATION:

Do you have Insurance? ☐ Yes ☐ No If yes, please present cards to reception

Primary:
Name of Company: ____

Insured's Name: ______________________ Insured's Birth Date: ______________

Secondary (if applicable):
Name of Company: ____

Insured's Name: ______________________ Insured's Birth Date: ______________

(Turn over)

Do you have a Primary Care Provider? If so, please supply the following information:

Physician's Name: ____

Clinic/Hospital Affiliation: ______________________________ Phone: ____________________

CONSENT FOR TREATMENT: Knowing that I (or ________________ [Patient Name]) have a need for routine preventative care and /or have a condition requiring diagnosis and medical, surgical or psychological treatment, do hereby consent to the following:

(1) All medical and surgical treatment, x-ray, laboratory, psychotherapy, and other medical or office procedures as may be performed or prescribed by my physician, provider or clinic personnel designated. I acknowledge that no guarantees have been made to me, and I am aware that I have the right to ask my Health Care Professional questions regarding any treatment or examination.

(2) To testing for HIV (AIDS) and/or Hepatitis should a health care worker have accidental exposure to my blood or other body substances.

ASSIGNMENT AND RELEASE:

(1) I authorize the release of any information necessary to process claims for services rendered to me. I request that payment by my insurance company be made either to me or the provider on any bills for services furnished to me during the effective period of this authorization. I understand that I am financially responsible to Destiny Family Medical Clinic for any charges not covered by my policy.

(2) **I further authorize release of medical and/or billing information to the following individual(s):**

Release to: ______________________________________ Relationship: ____________________

NO SHOW POLICY: A broken appointment is a loss to everyone. Please inform us one day in advance if you are unable to keep your appointment. Failure to appear for appointments may result in being charged a no show fee or being placed on a walk-in basis.

PATIENT SIGNATURE: ______________________________________ **Date:** ____________

Destiny Family Medical Clinic Prayer Partners can pray for me by my:

_____ First name _____ Initials _____ Anonymously

How did you hear about Destiny Family Medical Clinic? (Please check all that apply)

_____ Telephone book
_____ Friend/Family
_____ Ask-A-Nurse
_____ Avera Free Medical Clinic
_____ Community Health Center
_____ Other (please specify) ____________________

FOR COUNSELING PURPOSES ONLY

I authorize the use of spiritual interventions in counseling services that I may receive at Destiny Clinic in the future. They may include:

Prayer for me
Prayer with me
Bible reading
Bible reference

Patient Signature: ______________________________________ Date: __________