ENTERPRISE FAMILY HEALTHCARE

Darl W. Rantz, M.D., FAAFP

Patient Information

EMAIL _____

Last Name _____ Legal First Name _____ MI _____ Preferred Name _____ Preferred Language _____

SS# _____ _____ Single ____ Married ____ Widowed ____ Divorced

Date of Birth:_____ _____ **M / F**_ Patient Employed By: _____

Address: _____ Work Address: _____

_____ 1st Insurance_____Policy_____

City State Zip

Home Phone: (_____)_____ 2nd Insurance_____Policy:_____

Cell Phone: (_____)_____ Emergency Contact: _____

Work Phone: (_____)_____ Emergency Contact Phone: (_____)_____

Referring Provider/Physician: _____ Race_____ Ethnicity_____

Spouse OR Significant Other Information

Name:_____ Work Phone: (_____)_____

SS#: _____ Alternate Contact Number: (_____)_____

Date of Birth: _____ Employer: _____

Must Complete if *Under* 18

Father

Name:_____

Address: _____

SS#: _____

Date of Birth: _____

Work Phone: (_____)_____

Alternate Contact Number: (_____)_____

Employer: _____

Mother

Name:_____

Address: _____

SS#: _____

Date of Birth: _____

Work Phone: (_____)_____

Alternate Contact Number: (_____)_____

Employer: _____

Authorizations

*************Please Present Insurance Cards and Driver's License/Identification Card to Receptionist************

- I hereby authorize and request the medical treatment necessary for the care of the above named patient.
- I authorize the release of all medical records, drug and alcohol treatment records and psychiatric treatment records to my family physician, referring physician and to my insurance company, if applicable. I allow the fax transmittal of my medical records, named above, if necessary.
- I acknowledge full financial responsibility for services rendered by ENTERPRISE FAMILY HEALTHCARE. I understand payment is due at the time of service unless other definite financial arrangements have been made prior to treatment. I understand that I am responsible for any unmet deductibles and co-insurance fees. I understand that a no-show fee will be billed to me if I fail to show for a scheduled appointment.
- I understand that insurance companies have agreements with certain laboratories for lab work and that it is my responsibility to know which laboratory my insurance authorizes and to inform the staff of ENTERPRISE FAMILY HEALTHCARE as to which laboratory my insurance covers.
- I further authorize and request that insurance payments be made directly to ENTERPRISE FAMILY HEALTHCARE, for services rendered.

I have read and fully understand the above consent for treatment, release of medical information, financial responsibility and insurance authorization.

_____ _____ _____

Patient / Parent or Guardian **(Please Print)** Patient / Parent or Guardian **(Signature)** Date