



# Calvary Medical Clinic

"Where Your Healing Begins"

## ADULT INFORMATION FORM

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

Sex:  Male  Female SS#: \_\_\_\_-\_\_\_\_-\_\_\_\_ DL #: \_\_\_\_\_ ST: \_\_\_\_\_

Single  Married  Separated  Divorced  Widowed Home Phone #: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_

Cell Phone #: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_ Alternate Phone #: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_

Patient Or Parent / Guardian Email Address: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Patient Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_ Work Phone #: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_

Employer's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Spouse's DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Referred By:  Phone Book  Newspaper  Hospital  Another Physician  Friend/Relative Other: \_\_\_\_\_

### WITH WHOM MAY WE SHARE INFORMATION ABOUT YOUR ACCOUNT WITH?

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_

### WITH WHOM MAY WE SHARE INFORMATION ABOUT YOUR MEDICAL RECORDS WITH?

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_

**\*\*IN CASE OF AN EMERGENCY WHO MAY WE NOTIFY?\*** Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Hm Ph #: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_ Cell Ph #: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_

Wk Ph #: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_ Alternate Phone # (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_

**\*\*WHO IS RESPONSIBLE FOR PAYMENT\*\*** Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Hm Ph #: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_ Cell Ph #: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_ Wk Ph #: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_

Cardholder Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#: \_\_\_\_-\_\_\_\_-\_\_\_\_

Group # Or Plan Name: \_\_\_\_\_ Subscriber Or ID #: \_\_\_\_\_

For continuity of care, I give consent for Calvary Medical Clinic to obtain my prescription history. YES NO

**\*Payment is expected at the time services are rendered unless previous arrangements have been made. As a courtesy our office will file your insurance claims for the physician's fees in the event of hospitalization.\*** I also authorize Calvary Medical Clinic to release any information necessary in the course of my treatment required by the insurance company covering these procedures and I permit a copy of this authorization to be used in the place of the original. I understand that I am responsible for all amounts not covered by insurance. I have received a notice of this organization's privacy practices.

Patient or Parent/Guardian Signature: \_\_\_\_\_

Parent/Guardian Name(printed): \_\_\_\_\_