

MRN #: \_\_\_\_\_

**PATIENT BEING SEEN TODAY**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_<sup>Last</sup> Sex: \_\_\_\_\_<sup>First</sup> Driver's Lic #: \_\_\_\_\_<sup>Middle</sup>

Marital Status:  Married  Single  Divorced  Widowed  Separated  Domestic Partner

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

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

Primary Phone: \_\_\_\_\_  Home  Cell  Work

Secondary Phone: \_\_\_\_\_  Home  Cell  Work

E-mail: \_\_\_\_\_ Primary Language Spoken: \_\_\_\_\_

Primary Care Provider: \_\_\_\_\_ Referring Provider: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer Phone #: \_\_\_\_\_

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

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

Emergency Contact: \_\_\_\_\_ Emergency Phone: \_\_\_\_\_

Relationship to Emergency Contact: \_\_\_\_\_

**Responsible Party**

Name: \_\_\_\_\_<sup>Last</sup> \_\_\_\_\_<sup>First</sup> \_\_\_\_\_<sup>Middle</sup> Relationship to Patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_

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

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

Phone: \_\_\_\_\_ Driver's Lic #: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer Phone #: \_\_\_\_\_

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

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

**Responsible Party's Spouse**

Spouse's Name: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer Phone #: \_\_\_\_\_

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

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

I/we do hereby consent to and authorize the performance of all treatments, surgery and medical/behavioral health services by the staff of St. Joseph Heritage Medical Group which they may deem advisable. I hereby certify that, to the best of my knowledge, all statements contained hereon are true. I understand that I am directly responsible for all charges incurred for medical service for myself and my dependents regardless of insurance coverage, excluding only authorized covered services provided under a valid prepaid HMO contract.

I furthermore agree to pay legal interest, collection expenses, and attorneys' fees incurred to collect any amount I may owe. I also hereby authorize St. Joseph Heritage Medical Group to release information requested by insurance company and/or its representative.

\_\_\_\_\_ I fully understand that this agreement and consent will continue until cancelled by me in writing.  
\_\_\_\_\_ Authorization is hereby given St. Joseph Heritage Medical Group to render necessary medical, surgery or behavioral health treatment to any minor of which I am the parent or legal guardian.

Please sign: \_\_\_\_\_