EPHC

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Patient Demographics

(Last Name) **(First Name)** **(MI)**

(Address - mailing)

(City) **(State)** **(Zip)**

(SS#) **(DOB)** **(EMAIL)**

(Cell phone#) **(Home Phone#)**

(Address - physical) **Same as mailling address:** ◯

(City) **(State)** **(Zip)**

(Primary Insurance) **(ID#)**

(Secondary Insurance) **(ID#)**

(Subscriber Name) **Same as patient** ◯ **(DOB)** **(Relationship to patient)**

Race: **African American** ◯ **Hispanic** ◯ **HI/Pacific Islander** ◯ **White** ◯

Ethnicity: **Hispanic/Latino** ◯ **Not Hispanic/Latino** ◯

Guarantor Signature **Same as Patient** ☐ **Printed Name**

I agree to accept financial responsibility for services rendered and to accept the terms of the Financial Agreement, Assignment of Insurance Benefits, and Health Plan Contracts

Notice of Privacy Practices: Acknowledgment of Receipt

By signing below, I acknowledge being offered the "Notice of Privacy Practices" of Eastern Plumas Health Care (EPHC). EPHC may change our notice at any time and may be accessed via website @ **WWW.EPHC.ORG** or by contacting EPHC @ (530) 832-6500 or the Health Information Management office @ (530) 832-6506.

These individuals may receive Protected Health Information for one year from the date of signature above. This release may be withdrawn at any time with written notification to EPHC Clinics and Health Information Management.

(Individual 1 and relationship)

(Individual 2 and relationship)

Office Use Only

Entered by:

EPHC

Past Medical History:

Hospitalizations: When Where What for

Surgeries: When What for

Medications you are currently taking:

Name	Dose	Name	Dose

Allergies:

Social History:

Tobaco Use No ____ Yes ____ Type ____
How much: How Long:

Alcohol Use No ____ Yes ____ ____
How much: How Often:

Street Drugs No ____ Yes ____ ____
How much: How Often:

Marital Status: Single ____ Married ____ Divorced ____
Children: (No) ◯ (Yes) ◯ Number ____ Widowed ____
Occupation:
Employer:

Emergency Contact	**Phone #**	**Relationship to patient**	**DOB**

Consent for treatment:

The undersigned grants authority to medical staff of EPHC Clinics to administer and perform such examinations, treatments, or diagnostic procedures as may be deemed advisable or necessary for the care of the patient whose name appears on this record. The undersigned also authorizes the release of medical information necessary to process this claim and only to those individuals listed below. The undersigned also authorizes payment of medical benefits to the physician or supplier of services including outpatient lab, radiology, and services related to this visit. (This consent remains in effect for all treatments, exams, etc..for a period of one year or until consent is revoked in writing.)

Date Time Signature (patient or legal representative)

Print Name (if signed by legal representative or other than patient)