TODAY'S DATE / /	**PATIENT INFORMATION /CONSENT TO TREAT /HIPAA FORM** **FLINT HILLS FAMILY MEDICINE**

PATIENT INFORMATION — PLEASE PRINT

FULL LEGAL NAME (FIRST) (MIDDLE) (LAST)			(NICKNAME/AKA)
ADDRESS:	CITY:	STATE:	ZIP:
SOCIAL SECURITY NUMBER:	Provider: □ Dr. Schmid		Gender □ Male □ Female
DATE OF BIRTH:	E-MAIL ADDRESS:		Permission to have info (ex. Lab results) emailed? □ Yes □ No
Home Phone:	Other Phone: □ Cell □ Pager □ Fax	Ethnicity: □ Hispanic/Latino □ Not Hispanic/Latino	
Marital Status □ Married □ Single □ Divorced □ Life Partner □ Separated □ Widowed □ Other			Language (Other than English)
Race □ White □ Black/African American □ American Indian/Alaskan Native □ Asian □ Other Pacific Islander □Other			
EMPLOYER NAME:		Employer Phone:	

PHYSCIAN REFERRAL INFORMATION

Primary Care Physician:	Referring Physician:

RESPONSIBLE PARTY (INSURANCE) INFORMATION

Subscriber name:			
SS#		DOB:	

RESPONSIBLE PARTY INFORMATION (IF DIFFERENT THAN ABOVE)

FULL LEGAL NAME (FIRST) (MIDDLE) (LAST)				RELATIONSHIP: □ Spouse □ Parent □ Other
ADDRESS (IF DIFFERENT THAN ABOVE)	CITY	STATE	ZIP	HOME PHONE
SOCIAL SECURITY NUMBER:	DATE OF BIRTH:	WORK PHONE:		OTHER PHONE: □ Cell □ Pager □ Fax
EMPLOYER NAME:	STREET ADDRESS:	CITY:	STATE:	ZIP:

EMERGENCY AND OTHER INFORMATION

PERSON TO NOTIFY IN CASE OF EMERGENCY			RELATIONSHIP TO PATIENT
ADDRESS (NUMBER) (STREET)			(APT #)
CITY	STATE	ZIP	HOME PHONE
Home Phone:	Other Phone: □ Cell □ Pager □ Fax		Work Phone:
PHARMACY:			

INFORMATION

Insurance will be billed for all HMO's and PPO's with which we are contracted.
We accept assignment for Medicare; however, the patient is responsible for the copayment which Medicare calculates.
PLEASE NOTE THAT YOU ARE RESPONSIBLE FOR PAYMENT OF ALL FEES FOR PROFESSIONAL SERVICES EVEN THOUGH YOU MAY HAVE INSURANCE COVERAGE—this means that should the insurer fail to pay any sums due, you are responsible for their payment.