Ponderosa Family Physicians
Patient Profile

Patient Information

Name: _____ Gender: _____ DOB: _____

Address: _____

_____ Zip:

Home Phone: _____ Okay to leave detailed message (circle one): Yes No

Cell Phone: _____ Okay to leave detailed message (circle one): Yes No

Work Phone: _____ Okay to leave detailed message (circle one): Yes No

****PLEASE CIRCLE ONE PHONE NUMBER THAT IS YOUR PRIMARY CONTACT NUMBER****

SSN: _____ Marital Status (circle one): Single Married Divorced

Email address (PLEASE PRINT CLEARLY): _____

Race (circle all that apply): American Indian Asian Hawaiian African American White Latino Other

Ethnicity (circle one): Latino Not Latino

Primary Language (circle one): English Spanish Other

Emergency Contact (name, phone, relationship to patient): _____

Additional Contact (name, phone, relationship to patient): _____

Additional Contact (name, phone, relationship to patient): _____

Guarantor/Responsible Party Information (person who carries the insurance)

_____ patient same as guarantor _____ address same as patient

Guarantor Name: _____ DOB: _____ SSN: _____

Guarantor Address (if different than patient): _____

City, State, Zip _____

Guarantor Phone: _____ Relationship to Patient: _____

Primary Insurance Information

Insurance Company _____ Insured Id # _____ Policy/Group # _____

For Minors: Father's Name & Phone # _____

Mother's Name & Phone # _____

Primary Pharmacy

Pharmacy Name: _____ Pharmacy Phone #: _____

Pharmacy Cross Streets/Address: _____

Prescription History Consent

I, _____ (print name) hereby authorize Ponderosa Family Physicians to obtain my prescription history from external prescription sources to aid in medical history and treatment.

Signed _____ Date _____

Ponderosa Family Physicians
Spouse/Family Authorization (OPTIONAL)

I, _____ (print name) hereby authorize the disclosure of any of my health information to the following family members:

1. _____ Relationship _____

2. _____ Relationship _____

3. _____ Relationship _____

I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected. I understand that I may revoke this authorization at any time by signing the revocation section of a Family/Spouse authorization form and returning it to Ponderosa Family Physicians. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization. **I understand that I am under no obligation to sign this authorization.** I further understand that my ability to obtain treatment at Ponderosa Family Physicians will not depend in any way on whether I sign this authorization or not.

Signed _____ Date _____

Insurance Releases
By Patient, Parent or Legal Guardian

I authorize the release of any medical information necessary to process insurance claims. Further, I authorize payment of medical benefits to Ponderosa Family Physicians. In addition, I certify that all of the information above is accurate and complete.

Signed _____ Date _____