

Kaysville Clinic

Family Medicine

Patient Information:

Full Name: _____ Name Goes By: _____

Gender: Male Female

Marital Status: Single Married Divorced Widow

Date of Birth: _____

Address: _____

City/State/ZIP: _____

Please list your phone numbers in the order in which you prefer to be contacted.

Phone: _____ Home Work Other

Phone: _____ Home Work Other

Social Security Number: _____

Preferred Language: _____

Race (Please Circle One)

(American Indian) (Alaskan Native) (Asian) (African American)

(Native Hawaiian or Other Pacific Islander) (Caucasian) (Other)

Ethnicity (Please Circle One)

(Mexican American Indian) (American Indian) (Hispanic or Latino) (South American)

(Not Hispanic or Latino)

Patient Email:

Email Address: _____ May we contact you by email? Yes No
(For Kaysville Clinic Purposes Only)

Patient Employment:

Employment Status: Employed Retired Student Stay-at-Home

Unemployed Self-Employed Other

Patient's Employer: _____ Employer's Phone: _____

Employer's Address: _____ City/State/ZIP: _____

Emergency Contact Information:

Contact Name: _____ Contact Phone: _____

Relationship to Patient: _____

Responsible Party Information (Guarantor):

Full Name: _____ Date of Birth: _____

Patient's Relationship to Responsible Party: _____

Address: _____ City/State/ZIP: _____

Phone: _____ Home Work Other

Employer: _____ Employer's Phone: _____

Employer's Address: _____

Insurance Information (Please Provide Insurance Card at Check-In)

*If your insurance information changes, it is your responsibility to provide us with your updated information.

Primary Insurance Company: _____

Policy I.D. Number: _____ Policy Group Number: _____

Policy Holder Name: _____ Date of Birth: _____

Address: _____ Phone Number: _____

City/State/Zip: _____ Social Security Number: _____

Relationship to Patient: _____

Secondary Insurance Company: _____

Policy I.D. Number: _____ Policy Group Number: _____

Policy Holder Name: _____ Date of Birth: _____

Address: _____ Phone Number: _____

City/State/ZIP: _____ Social Security Number: _____

Relationship to Patient: _____

Self Pay/No Insurance

Please List Your Preferred Pharmacy: _____

Contact Preferences: When we are not able to reach you by phone, which method of contact would you prefer?

Leave a detailed message on your voicemail which could include lab results and information in regards to appointments that we have set up for you?

To indicate that we have called and need you to return our call?

Mail the information to you and have you contact us as needed?

Authorization for Use and Disclosure of Protected Health Information:

Please indicate if there is anyone besides yourself that you would like us to release your healthcare information to such as a spouse or a family member. If not please leave blank.

I represent and affirm that the above information is true and correct and it is my understanding that this office is relying on the above information that I have provided. I hereby give permission to Kaysville Clinic and Associates to administer treatment as may be deemed necessary in the diagnosis and treatment of my medical condition(s).

Signature of Patient or Parent/Guardian/Authorized Representative

Date

Printed Name of Signature Above

Relationship to Patient If Applicable

How did you hear about us?

- Internet Dex Directory Davis County Directory (Carr)
 Yellow Pages Insurance Company Friend/Family Member

Thank you for choosing Kaysville Clinic as your healthcare provider.
We are committed to providing you the best quality medical care.