FULL LEGAL NAME: _____ ADDRESS: _____

CITY/STATE/ZIP: _____ PHONE: _____

EMAIL ADDRESS: _____ GENDER: _____ BIRTHDATE: _____

SOCIAL SECURITY #: _____ INSURANCE COMPANY NAME: _____

INSURANCE COMPANY ADDRESS, CITY/STATE/ZIP: _____

INSURED MEMBER NAME, IF OTHER: _____ MEMBER ID: _____ MEMBER GROUP #: _____

TO VERIFY BENEFITS PHONE: _____ TO PRE-AUTHORIZE TREATMENT PHONE: _____

CLAIMS ADDRESS, CITY/STATE/ZIP: _____

EXISTING HEALTH CONDITIONS: _____

_____

_____

PHYSICIAN NAME, ADDRESS, CITY/STATE/ZIP, PHONE, FAX WHO IS TREATING EACH HEALTH CONDITION: _____

_____

_____

_____

CURRENT MEDICATION NAMES, STRENGTH, DOSAGE, ADMINISTERING INSTRUCTIONS: _____

_____

_____

_____

EMERGENCY CONTACT NAME(S), ADDRESS, CITY/STATE/ZIP, PHONE, EMAIL ADDRESS: _____

_____

_____

_____

_____

IN THE EVENT OF A MEDICAL EMERGENCY, I AUTHORIZE MY MEDICAL CARE PROVIDER TO CONTACT THE FOLLOWING CLERGY MEMBER:

CLERGY NAME: _____ AFFILIATED PLACE OF WORSHIP: _____

ADDRESS, CITY/STATE/ZIP: _____

PHONE: _____ EMAIL ADDRESS: _____

AND I AUTHORIZE MY MEDICAL PROVIDER TO GIVE INFORMATION TO OR TO GIVE ACCESS TO MY CLERGY MEMBER IN ORDER TO:

□ GIVE PERMISSION TO MAKE MY CLERGY MEMBER AWARE OF MY MEDICAL EMERGENCY

□ GIVE PERMISSION FOR MY CLERGY MEMBER TO ASK MEMBERS OF MY PLACE OF WORSHIP AND OTHERS TO PRAY FOR ME

□ GIVE PERMISSION FOR MY CLERGY MEMBER TO VISIT ME

□ GIVE PERMISSION FOR MY CLERGY MEMBER TO ADMINISTER ANNOINTING OF THE SICK AND/OR LAST RITES

□ GIVE PERMISSION FOR MY CLERGY MEMBER TO RECEIVE MEDICAL UPDATES ON MY CURRENT CONDITION

I HAVE SIGNED A NOTARIZED MEDICAL POWER OF ATTORNEY FORM, DATED ON: _____

THE FORM(S) ARE AT THE FOLLOWING LOCATION ADDRESS, CITY/STATE/ZIP, SPECIFIC LOCATION THEREIN, OR WITH THE FOLLOWING NAMED PERSON(S), ADDRESS, CITY/STATE/ZIP, PHONE, EMAIL ADDRESS: _____

_____

_____

_____

I HAVE SIGNED A NOTARIZED ADVANCED DIRECTIVE FORM, OR LIVING WILL, DATED ON: _____

THE FORM(S) ARE AT THE FOLLOWING LOCATION ADDRESS, CITY/STATE/ZIP, SPECIFIC LOCATION THEREIN, OR WITH THE FOLLOWING NAMED PERSON(S), ADDRESS, CITY/STATE/ZIP, PHONE, EMAIL ADDRESS: _____

_____

_____

_____

I AM THE CARETAKER OF AN INFANT, SMALL CHILD, DISABLED OR ELDERLY PERSON, OR PET(S) IN MY HOME. PLEASE INFORM MY EMERGENCY CONTACTS AND/OR LOCAL LAW ENFORECMENT OF THE CARETAKER NEEDS OF:

_____

FULL LEGAL NAME BIRTHDATE □ INFANT □ SMALL CHILD □ DISABLED □ ELDERLY □ PET

_____

SPECIAL NEEDS

I HAVE DESIGNATED IN THE EVENT OF MY DEATH, I AM AN ORGAN DONOR. THE FORM(S) ARE AT THE FOLLOWING LOCATION ADDRESS, CITY/STATE/ZIP, SPECIFIC LOCATION THEREIN, OR WITH THE FOLLOWING NAMED PERSON(S), ADDRESS, CITY/STATE/ZIP, PHONE, EMAIL ADDRESS:

_____

_____

MY IN-NETWORK PRIMARY CARE PHYSICIAN NAME, ADDRESS, CITY/STATE/ZIP, PHONE, EMAIL, FAX: _____

_____

MY IN-NETWORK SPECIALIST(S) PHYSICIAN NAME(S), ADDRESS, CITY/STATE/ZIP, PHONE, EMAIL, FAX: _____

_____

_____

_____

□ A REFERRAL FOR A NEW SPECIALIST IS REQUIRED TO BE SUMBITTED BY MY PRIMARY CARE PHYSICIAN AND ACCEPTED PRIOR TO SPECIALIST OFFICE VISIT

MY IN-NETWORK CLINICAL LABORATORY NAME, ADDRESS, CITY/STATE/ZIP, PHONE, EMAIL, FAX: _____

_____

_____

_____

MY IN-NETWORK RADIOLOGY NAME, ADDRESS, CITY/STATE/ZIP, PHONE, EMAIL, FAX: _____

_____

_____

_____

MY IN-NETWORK HOSPITAL NAME, ADDRESS, CITY/STATE/ZIP, PHONE, EMAIL, FAX: _____

_____

_____

_____

MY IN-NETWORK PHARMACY NAME, ADDRESS, CITY/STATE/ZIP, PHONE, EMAIL, FAX: _____

_____

_____

_____

INFORMATION ON THIS SHEET WAS LAST UPDATED ON: _____ _____

DATE PATIENT SIGNATURE