|  |  |
| --- | --- |
|  | 1605 E Riverside Dr  Eagle, ID 83616  208-939-6227 |

**MEDICAL PATIENT INFORMATION**

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth:** \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

(FIRST) (MI) (LAST)

**Address:**

(STREET) (CITY) (STATE) (ZIP)

**Home Phone:**  (\_\_\_\_) \_\_\_\_\_\_\_­\_\_\_\_\_ **Work Phone:** (\_\_\_\_) \_\_\_­\_\_\_\_\_\_\_\_\_ ext: \_\_\_\_\_\_\_\_­ **Cell Phone:** (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_

May we leave a voicemail? □ Yes □ No ­­­ Preferred Message Phone: □ Home □ Work □ Cell

**Provide your email address for appt reminder/upcoming events/promotional info:**

**Marital Status:** □ Single □ Married □ Divorced □ Widow Gender: □ Male □ Female

**Student:** □ Yes □ No  **Employer:**

**Preferred Language:** □ English □ Spanish □ Other

**RACE:** □ Native Hawaiian or Other Pacific Islander □ Black or African American

&□ American Indian or Alaska Native □ White □ Asian □ Other

**ETHNICITY: □** Hispanic or Latino □ Not Hispanic or Latino □ Unknown

**Emergency Contact:**

**Relationship to patient:** □ Spouse □ Parent □ Child □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_)

**Referring Physician:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Primary Care Physician:**

**How did you hear about us?** □ Patient □ Family/Friend □ Physician □ Insurance □ Our Website □ Radio □ Internet/Search Engine

□ Magazine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Other

**PERSON RESPONSIBLE FOR ACCOUNT**

|  |
| --- |
| **Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_  (FIRST) (MI) (LAST)    **Address:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (STREET) (CITY) (STATE) (ZIP)  **Relationship to patient:** □ Self □ Spouse □ Parent □ Child □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**MEDICAL INSURANCE INFORMATION**

Photocopy of Insurance Card(s) and Federal or State issued Identification card is required.

**Primary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Policy Holder:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Policy Holder Address:**

(STREET) (CITY) (STATE) (Zip)

**Relationship to patient:** □ Self □ Spouse □ Parent □ Other

**Secondary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Policy Holder:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Policy Holder Address:**

(STREET) (CITY) (STATE) (Zip)

**Relationship to patient:** □ Self □ Spouse □ Parent □ Other

**ALLOW ACCESS OF MY PROTECTED HEALTH INFORMATION (PHI) TO:**

|  |
| --- |
| 1) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Assignment of Benefits & Release of Information**: I hereby assign all applicable benefits and direct that payment be made directly to Keller Skin Care (KSC) for all services provided to/for me during my visit. I also authorize KSC to furnish medical and other information necessary to process claims on my behalf. This information may be released to my personal physician and upon request, to any other healthcare provider who may need the information for continuity of care. This release of information will remain in effect until revoked by me in writing.

**Financial Responsibility**: Payment is required for all services at the time they are rendered unless you are enrolled in an insurance plan in which we participate. Any applicable co-payments will be collected at the time of service.

**HIPAA Notice of Privacy Practices**: As required by law, I have been given the opportunity to read the notice describing information about privacy practices followed by Keller Skin Care.

I certify the above information is correct to the best of my knowledge.

**Signature of Patient/Legal Guardian:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_\_