HILDEBRAN MEDICAL CLINIC PATIENT CONSENT FORM

Patient Name _____Date of Birth _____/____/_____
Last Name First Name MI Month Day Year

Social Security #_____ Male Female Single Married Divorced

Mailing Address _____ City/State: _____ Zip_____

Home Phone_____ Cell #_____ Do you receive text messages Y__N__

E-mail address_____

Employer _____ Work Phone _____

Family Member who has received care at the clinic? _____Phone#_____

WHO IS RESPONSIBLE FOR THIS PATIENT'S MEDICAL EXPENSES

Self ____ Parent ____ Spouse____ (If Self - go to insurance section)

Parent or Spouse Name: _____Date of Birth ____/____/_____

Street Address_____City/State_____Zip_____

Social Security #_____ Employer_____ Work#_____

INSURANCE INFORMATION

Primary Insurance Co. _____Subscriber Name_____
_
Secondary Insurance Co. _____Subscriber Name_____

PERSON TO NOTIFY IN CASE OF EMERGENCY

Name_____ Relationship to you _____Phone#_____

SIGNATURE _____ Date_____

I hereby authorize the release of any medical information necessary to process health Claims. I request payment of the benefits to be made directly to Hildebran Medical Clinic. Any unexpected balance left after insurance payment has been resolved will be due in full within 90 days of notification from this office. If further understand that any sums due me if less than $100.00 will be credited to my medical account. As a patient I have the right to review the provider's privacy policies. I also have the right to request restrictions, revoke consent for medical records in writing. I authorize my physician to share information within the practice or with health care professionals who may be consulted.

This authorization is valid unless rescinded in writing. A photocopy is as valid as the original.
I have read and understood all of the above and have given truthful information to the best of my knowledge.