

# **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: \_\_\_\_\_

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.

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*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).*

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Signature of Patient or Parent/Guardian/Authorized Representative

Date

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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.