NEWMAN REGIONAL HEALTH EXPRESS CARE

PATIENT INFORMATION:

Legal Name: Last:_____ First:_____ Middle:_____

DOB:_____ Sex: M or F Mother's Name:_____ Father's Name:_____

SS#:_____ Primary Care Provider:_____ Referring Provider:_____

Phone: Home:_____ Cell:_____ Work:_____

Marital Status:_____ Language:_____ Race:_____ Ethnicity: ❑ Not Hispanic ❑ Hispanic

Address:_____

City State Zip Code

I would like to enroll for the patient portal: Yes ❑ No ❑ Email:_____

(Parents may have access to their child's portal until 12 years of age due to Kansas Laws)

Employer:_____ Unemployed ❑ Retired ❑ Student ❑

Other Names Used: Nickname:_____ Maiden/Previous Last Name:_____

Preferred Pharmacy:_____ Alternate Pharmacy:_____

INSURANCE INFORMATION:

Primary Insurance Company:_____ Policy #:_____ Group #:_____

Name of Subscriber:_____ DOB:_____ Marital Status:_____ Relationship:_____

Secondary Insurance Company:_____ Policy #:_____ Group #:_____

Name of Subscriber:_____ DOB:_____ Marital Status:_____ Relationship:_____

RESPONSIBLE PARTY/BILLING INFORMATION (Parent who is signing this consent is the responsible party)

Responsible party's relationship to patient: ❑ SELF (skip to the next section) ❑ Mother ❑ Father ❑ Other:_____

Legal Name: Last:_____ First:_____ Middle:_____

DOB:_____ SS#:_____ Phone: Home:_____ Cell:_____

Employer:_____ Phone: Work:_____

PATIENT DISCLOSURE: ❑ If there is no one to list please check the box

I authorize this person to communicate with NRHMP regarding my health information including appointments, test results, medications and my general condition. This does NOT entitle this person to copies of my medical record.

Name:_____ Relationship:_____

Name:_____ Relationship:_____

PRIMARY CONTACT ❑ If there is no one to list please check the box

Name:_____ Relationship:_____

Phone: Home:_____ Cell:_____ Work:_____

SECONDARY CONTACT:

Name:_____ Relationship:_____

Phone: Home:_____ Cell:_____ Work:_____

CONSENT FOR TREATMENT:

I consent to the procedures and treatment which may be performed by Newman Regional Health Medical Partners. I understand that the practice of medicine is not an exact science and that diagnosis and treatment may involve risks. I acknowledge that no guarantees have been made as to the results of examinations and treatment.

I certify that I have read and fully understand the Financial Policy for NRHMP given to me at registration. I, as the patient/legal guardian, or as duly authorized agent of the patient, execute the above agreement by signing below, I agree to all the terms and statements listed on this form.

By my signature below, I acknowledge that I have received or have been offered a copy of NRHMP Notice of Privacy Practices. By signing below I am authorizing NRHMP to call the contact numbers listed on this form. I consent to NRHMP staff and/or automated message system to leave a message concerning my private health information on voicemails, text messages, and email if I have provided that information. NRHMP may also leave a message with an individual that answers the phone numbers listed on this page. NRHMP may also send correspondence through the mail to the address listed on this page.

Patient/Legal Guardian Signature:_____ Date:_____

Print Name if other than Patient Signing:_____

Relationship to Patient:_____ Legal Documents on File if necessary: ❑ Yes ❑ No

Staff Initials: _____