HELTON
family medicine

PATIENT INFORMATION (PLEASE PRINT)

PATIENT NAME: _____
(LAST) (FIRST) (MI)

SSN: _____-____-_____ **EMAIL: _____**

ADDRESS: _____
(STREET/PO BOX/APT #)

_____
CITY STATE ZIP

PRIMARY PHONE: _____ SECONDARY PHONE: _____

BIRTHDATE: _____ AGE: _____ MALE: ☐ FEMALE: ☐

MARITAL STATUS: MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED ☐

RACE: _____ IS IT OK TO CONTACT YOU AT WORK: _____

PATIENT EMPLOYER: _____ OCCUPATION: _____
(SKIP IF MINOR)
EMPLOYER ADDRESS: _____ WORK PHONE: _____

EMERGENCY CONTACT

NAME: _____ RELATIONSHIP: _____

PRIMARY PHONE: _____ SECONDARY PHONE: _____

FAMILY INFORMATION

SPOUSE: _____ DOB: _____ SSN: _____-____-_____

CHILDREN: _____ DOB: _____ (IF MORE SPACE IS NEEDED,

_____ DOB: _____ PLEASE USE BACK OF THIS SHEET)

I authorize the release of any medical information necessary to process insurance claims. I also authorize assignment of insurance benefits to T. Michael Helton, MD in the event my insurance is filed as a courtesy. I understand I am fully responsible for payment in full for services rendered by T. Michael Helton, MD, I understand that I will also incur the cost of said collections, which include reasonable attorney fees and court costs. I further authorize the release of any pertinent medical records to any physician and/or facility to which I may be referred. I give my consent for medical treatment of the patient names above to T. Michael Helton, MD. I agree to allow Dr. Helton to review my external medication history.

I hereby acknowledge that I was given the opportunity to read a copy of the Notice of Privacy Practices of T. Michael Helton, MD.

SIGNATURE: X _____ DATE: _____
IF PATIENT IS A MINOR, PARENT OR GUARDIAN MUST SIGN AUTHORIZING CONSENT