# ADULT

**Patient Demographic Information**

**Patient's Name**_____

**First** **Middle Initial** **Last**

**Date of Birth:** _____ **Social Security #:** _____

**Marital Status:** S M W D **Gender:** Male or Female **Race:** _____

**Ethnicity:** Hispanic Non-Hispanic Other

**Home Phone #:** _____ **Cell Phone #:** _____

**Preferred Method of Contact:** _____ **Ok to leave Message:** Yes No

**Email Address:** _____

**Street Address:**_____

**City:** _____ **State:** _____ **Zip Code:** _____

Mailing Address (**if different**): _____

City: _____ State: _____ Zip Code: _____

**Employer Name:** _____

**Work Phone #:** _____ **Position:** _____

**Spouse's Name** _____

Date of Birth: _____Social Security #: _____

Home Phone #: _____ Cell Phone #: _____

Employer Name: _____ Work Phone #: _____

**Emergency Contact Name:** _____

**Phone #:** _____ **Relation:**_____

**Preferred Pharmacy Information Pharmacy on file for medications and refills**

Name: _____ Phone #: _____

**Primary Insurance:** _____

**Policy #:** _____ **Group #:** _____

**Name of Primary Insured**: _____ **Relation to patient:** _____

**Primary Insured Date of Birth:** _____ **Social Security #:** _____

Secondary Insurance **(If Any):**_____

Policy #: _____ Group #: _____

Name of Primary Insured: _____Relation to patient: _____

Primary Insured Date of Birth: _____ Social Security #: _____

**I authorize the following individuals listed below to be given information concerning my health and wellbeing. Information may include appointments, test results, and medications. (Must also include your Emergency Contact)**

Name: _____Relationship:_____

Name: _____Relationship:_____

Name: _____Relationship:_____

**List of any immediate family members who also are patients of WMC**: _____

_____

| **PAST MEDICAL HISTORY** | | |
|---|---|---|
| Do you now or have you ever had: | | |
| ❑ Diabetes | ❑ Heart murmur | ❑ Crohn's disease |
| ❑ High blood pressure | ❑ Pneumonia | ❑ Colitis |
| ❑ High cholesterol | ❑ Pulmonary embolism | ❑ Anemia |
| ❑ Hypothyroidism | ❑ Asthma | ❑ Jaundice |
| ❑ Goiter | ❑ Emphysema | ❑ Hepatitis |
| ❑ Cancer (type) _____ | ❑ Stroke | ❑ Stomach or peptic ulcer |
| ❑ Leukemia | ❑ Epilepsy (seizures) | ❑ Rheumatic fever |
| ❑ Psoriasis | ❑ Cataracts | ❑ Tuberculosis |
| ❑ Angina | ❑ Kidney disease | ❑ HIV/AIDS |
| ❑ Heart problems | ❑ Kidney stones | |
| Other medical conditions (please list): | | |

**Financial Responsibility**

Payment is due at the time of service. I understand I will be expected to pay any deductibles, co-payments, and fees at the time of any office related service. I will be responsible for any patient balances after insurance has been filed. I understand that Wilmer Medical Clinic has the right to refer my account to an outside collection's agency after a period of 90 days.

**Initial:** _____

**Electronic Communications**

WMC, and/or our agents may contact you by telephone at any number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using the email address you provide to use.

**Initial:** _____

**Consent to Treat**

I hereby give authorization to all the physicians and staff at Wilmer Medical Clinic to treat myself and/ or my minor child. I understand that there are no guarantees regarding the result of treatment and/or examinations. I hereby give authorization for payment of insurance benefits to be made to Wilmer Medical Clinic for services rendered. I understand that I am financially responsible for all charges whether they are covered by insurance. In case of default, I agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize this healthcare facility to release all information necessary to secure payment of benefits and that a photocopy of this agreement shall be as valid as the original

**Initial:** _____

## Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have been provided the Wilmer Medical Clinic's Notice of Privacy Practices ("Notice"):

- WMC will use my health information for the purpose of medical treatment, to obtain payment for treatment, and WMC's health care operations.
- The notice explains in detail my individual rights and how I may exercise these rights.
- WMC will also use and share my health information as required/permitted by law.

**Patient's Complete Legal Name:** _____

**(Please Print)**

**Patient's DOB:** _____ **Date:**_____

**Signature:** _____ **Witness:**_____

(Patient or Legal Representative *)

*May be requested to show proof of representative status