Orcas Family Health Center
1286 Mt. Baker Rd., Eastsound, WA 98245
Phone: 360-376-7778
Fax: 360-376-7706

Patient Information Form

Patient

Legal Name: First_____ MI ___ Last _____

Maiden/Other_____Date of Birth_____Soc. Sec. # _____Gender ____

Mailing Address_____City_____State____Zip_____

Home Phone _____ Work Phone _____

Cell Phone_____ E-Mail _____

Employer_____ Retired: Y N Student : Y N Full Time Part Time

Married: Y N Preferred Language _____

Race/Ethnicity: Asian Caucasian African American Hispanic/Latino

Native American/Alaska Native Native Hawaiian/Pacific Islander

Responsible Party/Guarantor

Name _____Relationship: _____

Mailing Address_____City_____State____Zip_____

Home Phone _____

Insurance

Insurance Carrier_____Policy Number _____

Primary Care Provider_____

Policy Holder _____ ・Father ・Mother ・Spouse ・ Birth Date _____

Emergency Contact

Name _____ Relationship_____

Home phone_____ Work _____ Cell _____

Acknowledgement and Signature for Release, Assignment, Financial Responsibility, and Privacy Notice:
I hereby give permission for the above patient to receive treatment which the attending medical practitioner considers necessary. If insured, I authorize my insurance benefits be paid directly to Orcas Family Health Center and I will be responsible for any balance due not paid by my insurance and authorize the provider/insurance company to release any information required to process my medical claims. If I do not have insurance, I understand that I am responsible for payment of all charges. I agree with the financial policy and acknowledge receipt and Notice of Privacy Practices, describing how my health information may be used or disclosed.

Signature X_____ **Date** _____

Relationship _____(i.e. self, mother, father, etc.)

For office use
Entered in Healthwind _____ Entered in Quanum _____

Updated 03/2020