PATIENT NAME:

_____

(Last Name) (First Name) (Middle Name)

DOB: _____**SSN:** _____**GENDER**: _____

MAILING ADDRESS: _____**CITY:** _____**STATE:** _____**ZIP:** _____

BEST CONTACT PHONE:_____**EMAIL:**_____

MAY WE LEAVE A DETAILED MESSAGE? PHONE YES / NO **EMAIL** YES / NO

MAY WE SEND CONFIDENTIAL MEDICAL INFORMATION TO THE ADDRESS LISTED ABOVE? YES: ____ NO: ____

EMPLOYER: _____

EMPLOYER PHONE NUMBER:_____

(For Injured Workers)

RESPONSIBLE PARTY:_____RELATIONSHIP:_____DOB:_____SS#_____

(Name)

WORK RELATED NO_____ **YES** _____**DATE OF INJURY**_____

AUTO ACCIDENT NO_____**YES**_____ **DATE OF INJURY**_____

PREFFERED LANGUAGE: _____

RACE: AMERICAN INDIAN OR ALASKAN NATIVE NATIVE HAWAIIAN/PACIFIC ISLANDER

DECLINED

ETHNICITY:

ASIAN WHITE NON-HISPANIC

AFRICAN AMERICAN OTHER _____ HISPANIC/LATINO

HISPANIC DECLINED

EMERGENCY CONTACT _____PHONE: _____ RELATIONSHIP: _____

PRIMARY HEALTHCARE PHYSICIAN: _____ **PHARMACY:** _____

PRIMARY INSURED NAME:_____

BIRTHDATE:_____

PHONE NUMBER:_____ **RELATIONSHIP TO PATIENT:**_____

HOW DID YOU HEAR ABOUT US: NEWSPAPER DRIVING BY FAMILY/FRIENDS PHYSICIAN REFERRED

INTERNET POSTCARD BILLBOARD ESTABLISHED PATIENT

EVENT SCHOOL RIHC WORK RADIO

I, understand, and verify that the above information is accurate to the best of my knowledge. I understand that payment is required at time of service and maybe in the form of cash, debit or credit card. Your Care, LLC does not accept personal checks. I authorize Your Care, LLC to submit a claim to my insurance carrier for me and I assign all insurance payments to Your Care, LLC. I understand that I am financially responsible for any charges not covered by my insurance.

I, the patient or authorized representative, consent to any examination, evaluation and treatment regarding my illness, injury or other health concern affecting me at the time of check in at Your Care, LLC. These services may include but are not limited to laboratory procedures, x-ray examinations, and medical or surgical treatment or procedures.

_____ _____

PATIENT SIGNATURE OR RESPONSIBLE PARTY **DATE**