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:** _____________

PREFERRED LANGUAGE: _____________________

RACE: AMERICAN INDIAN OR ALASKAN NATIVE
ASIAN
AFRICAN AMERICAN
HISPANIC
NATIVE HAWAIIAN/PACIFIC ISLANDER
WHITE
OTHER __________________
DECLINED

ETHNICITY:
NON-HISPANIC
HISPANIC/LATINO
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 REFFERED RADIO
INTERNET POSTCARD BILLBOARD ESTABLISHED PATIENT WORK
EVENT SCHOOL RIHC

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**