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 #:**_____

(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:
ETHNICITY:

- ☐ AMERICAN INDIAN OR ALASKAN NATIVE
- ☐ ASIAN
- ☐ AFRICAN AMERICAN
- ☐ HISPANIC
- ☐ NATIVE HAWAIIAN/PACIFIC ISLANDER
- ☐ WHITE
- ☐ OTHER _____
- ☐ 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**