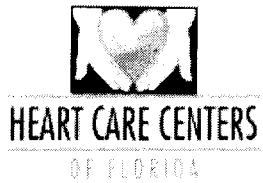

CONFIDENTIAL PATIENT INFORMATION

Date: _____

Name: (Last) _____(First) _____ (MI)_____

SS#: _____ Birth Date: _____ Age: ___ Sex: ____

Marital Status: _____ Race _____ Language _____

Home Phone: _____ Cellular Phone: _____

Northern Phone:_____ Work Phone: _____

Primary Care Name:_____ Referred By: _____

Email Address: _____

Permanent Billing Address:

_____
Street City State Zip Code

Address:_____
Street City State Zip Code

Spouse's Name: _____ Birth Date:_____ SS#_____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone: _____

Employer Name: _____ Employer Number: _____

Policy Holder Information: Patient

Primary Policy Holder Name: _____Secondary Policy Holder Name: _____
Primary Policy Holder Phone: _____Secondary Policy Holder Phone: _____

Primary Policy Holder SS#: _____ Secondary Policy Holder SS#: _____
Primary Policy Holder DOB: _____ Secondary Policy Holder DOB: _____

Do you have an Advance Directive? Yes No
If yes, what type? _____
Living Will ___ Do Not Resuscitate ___ Assignment of Healthcare Power Attorney__ Assignment of Surrogate__

I grant permission to the employees of HCCF Group to render care to me and expedite the orders of physician. I further authorize release of this information to other healthcare providers associated with my care.
Patient Signature _____ Date_____