Hayden Lake Family Physicians

Patient Chart Number:

Last Name	First Name	MI	Gender	Birth Date
Address		City	State	Zip Code
Home Phone	Work Phone	Cell Phone/Other	SSN	
Email Address		Attending Provider		Marital Status
Employer:	Telephone:	Address:		

The following data is collected and used to track quality of care. This information is kept confidential and goes directly into your medical record.

Race
- ☐ White
- ☐ Asian
- ☐ Black/African American
- ☐ American Indian or Native Alaskan
- ☐ Native Hawaiian/Pacific Islander
- ☐ Other

Other___________

Hispanic/Latino
- ☐ Yes
- ☐ No

Language
- ☐ English
- ☐ Spanish
- ☐

RESPONSIBLE PARTY INFORMATION

Last Name	First Name	MI	Birth Date	Gender
Address	City	State	Zip Code	Relationship
Home Phone	Work Phone		SSN #	

PRIMARY INSURANCE		SECONDARY INSURANCE	
Insurance Name		Insurance Name	
Claims Address		Claims Address	
Subscriber's Name		Subscriber's Name	
Subscriber ID	Group No.	Subscriber ID	Group No.
Subscriber SSN	Subscriber Birth Date	Subscriber SSN	Subscriber Birth Date

I hereby authorize Hayden Lake Family Physicians (HLFP) to examine and treat my child or me and to perform such diagnostic tests and/or x-rays as may be necessary for the duration of treatment for services rendered at HLFP. I hereby authorize the release of any medical information necessary to process my Medicare and/or insurance claims and for any benefits payable under my policy be paid directly to HLFP. I understand that this information may include information related to the diagnosis, and/or treatment of alcohol/substance abuse, psychological/mental health disorders and/or HIV. I understand that I am responsible for the fees for all services rendered (and equipment/supplies provide) to my child or me. I understand and guarantee payment of charges incurred is due at time of service unless other definite financial arrangements with the billing department have been made prior to treatment. I agree that, in the event I default and do not pay my balance, reasonable costs of collection, and/or attorney fees, may be added to the amount due on the account and I agree to be financially responsible for those additional charges. I have read and fully understand the above consent for treatment from HLFP.

Signature of Patient/Responsible Party ________________________________

Dated ________________