PATIENT INFORMATION

For Refuah Office Use: Medical Record #:______________ Date: ___/____/____

Last Name: ____ First Name: _____________________________________

Patient Mother's Maiden Name: _____________________ First Name: _____________________________________

Address: ____ Apt#: ____

City: ____ State: __________________________ Zip: ____________

Email Address: ____________________________________ Web Enable ☐Yes ☐No

I authorize Refuah Health Center to disclose, verbally, in writing or via the patient portal, individually identifiable health information about me, or the patient as listed above, to the following:

______________________________ ______________________________ ______________________________

Home Phone # :(___) ________________ Cell # :(___) ________________

Birth Date: ____/_____/_____ ☐Male ☐Female

Primary language spoken: ____

In case of emergency, contact (other than patient):____

Home Phone #: ( ) ________________ Cell #: ( ) _______________

Relationship to patient: ____

Race: ☐White ☐Black or African-American ☐Asian ☐American Indian or Alaskan
☐Native Hawaiian or Other Pacific Islander ☐Refuse to Report

Ethnicity: ☐Hispanic or Latin ☐Not Hispanic or Latin ☐Unknown

Diversity (Check all that apply):
☐Handicapped ☐Visually Impaired ☐Hearing Impaired ☐Cognitively Impaired

Employment Status:

☐Employed full-time. Employer's Name ____

☐Employed part-time. Employer's Name ____

☐Not Employed

☐Self Employed

☐Retired

☐On active military duty

☐Reserved for national assignment

☐Veteran

Migrant Worker: ☐Not a Farm Worker ☐Migrant ☐Seasonal

Living Arrangements:

☐I live in my own apartment/house, which is my permanent residence

☐I temporarily joined households with someone/another family

☐I live with different people and move around

☐I live in a shelter

☐I live on the street

☐I live in public housing

Responsible Party/Parties:

Name of person(s) responsible for this account:

______________________________ ______________________________

Home Phone # :(___) ________________ Cell # :(___) ________________

Address: ____

Relationship(s) to patient: ____________________ ____________________

Pharmacy Name and Address: ____

Insurance Information:

☐I am insured (please provide a copy of your insurance card to Refuah)

Primary Insurance Name: ______________________ ID#____________

Insurance Address: ____

Secondary Insurance Name: ______________________ ID#____________

Insurance Address: ____

☐ I am not insured and would like to make payments by using the Sliding Fee Scale Program.

Consent for Testing and Treatment.

I give permission to Refuah Health Center to perform such tests, treatments and procedures as ordered by the medical/dental staff for diagnostic and/or therapeutic purposes, including but not limited to, x-rays and the administration of pharmaceutical products and medication, in addition to the drawing of blood. I acknowledge that no guarantees or assurances have been made to me concerning the results of findings intended from treatment or examination at Refuah Health Center.

I understand and acknowledge that Refuah prohibits all photography and audio/video recording on its premises and agree to refrain from taking any photos/videos/audio recordings while I am on site.

Authorization:

By signing this form, I attest that all of the information above is accurate and true to the best of my knowledge and belief.

X____ X____________

Signature of patient or legally authorized representative Date

X____ X____________

Signature of Witness Date