**Patient Name:** First \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Nickname\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status: Single Married Divorced Widowed

Address: Street \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_

Phone: Home\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_ Cell\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_\_\_\_\_ Work\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employed By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­\_\_\_

Employer Address: Street \_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_ Zip\_\_\_\_\_\_

**Guarantor (Required):** personresponsible for what the insurance does NOT pay

Guarantor: Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: Street \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_

**Emergency Contact:**

In case of an emergency, who should we notify? ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­\_\_\_\_\_\_­\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insured Employee (if other than patient):**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Insured:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN:­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: Street \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_

Please sign below if you agree to receive the results of your labs via telephone messaging and/or text messaging.

**Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Chisolm and Cromer, LLC has installed an Electronic Health Record called eClinical to help serve you better. Part of the new system is a “Patient Portal” that allows you to access your medical records online. If you decide to utilize this feature, you will receive an email with instructions on how to access your records.

**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**E-mail Address:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Check One:**

I do want to utilize the Patient Portal \_\_\_\_\_\_

I do NOT want to utilize the Patient Portal \_\_\_\_\_\_

**CONSENT FOR TREATMENT**

Permission is hereby given for any medical/surgical procedures, x-rays, drug or laboratory test, medications, and/or exam as may be deemed necessary by the patient. In the case of a non- emancipated minor, the consent below is given on their behalf. I also, consent to obtain RX history if needed.

**SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_\_**

**FINANIAL RESPONSIBILITY**

I understand it is the responsibility of each patient to arrange for payments for the medical series received in this office. I hereby authorize any insurance benefits to be paid directly to Chisolm and Cromer, MD, LLC, and recognize my responsibility to pay for all non- covered services. I also authorize the release of any information necessary to process an insurance claim. Charges for all minors are the responsibility of the parent, guardian, or individual who is presenting the child for treatment. I understand that all accounts placed with any outside collection services or small claims court will have additional fees up to, but not limited to $65.00 additional cost. I also understand that all returned checks marked nonsufficient will have a $25.00 service fee.

**SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_\_**

**IF YOU WANT MEDICAL INFORMATION RELEASED TO FAMILY, PLEASE COMPLETE AND SIGN SECTION #1 BELOW. IF YOU DO NOT WANT MEDICAL INFORMATION RELEASED TO ANYONE OTHER THAN YOURELF, PLEASE SIGN SECTION #2 BELOW. \*\*\* DO NOT SIGN BOTH PLACES. \*\*\***

1. **CONSENT TO RELEASE MEDICAL INFORMATION AND/OR RECORDS TO SPOUSE OF OTHER FAMILY MEMBER:**

I hereby authorize Chisolm and Cromer, MD, LLC to release any information contained in my medical record to the person/persons listed below:

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ B. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ C. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **Do not release information to anyone:**

I do not authorize any medical information to be released to anyone other than myself.

**SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_\_**

**VOICEMAIL OR MESSAGES (optional)**

I hereby authorize messages to be left on voicemail system or answering machine at the following number:

Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_\_**

**ACKNOLWEDGEMENT OF PRIVACY RIGHTS**

By signing below, I acknowledge that I have received copy of Chisolm and Cromer, MD, LLC notice of Privacy Practices and Individual Rights (enclosed with this sheet).

**SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_\_**