Patient Data Sheet

Date: _____/_____/_____

Name: _____
Last First Middle

Date of Birth: _____/_____/_____ SSN: _____-____-_____ Age: _____ Sex: _____ Marital Status: _____

Spouse: _____ United States Veteran: □ Yes □ No Homeless Status: □ Not Homeless □ Homeless

Address: _____
_____

Phone Number (Home) _____ (Cell) _____ (Work) _____
Email Address_____

Country of Origin: _____ Ethnicity: Is the patient Hispanic or Latino? □ Yes □ No

Race (mark all that apply): □ White □ Black/African American □ Asian □ American Indian/Alaska Native □ Native Hawaiian □ Other Pacific Islander

Person to Contact in Case of Emergency: _____
Relationship: _____ Phone (Home) _____ (Cell) _____

Employer: _____Address:_____

Name of Insurance: _____
Group #_____ ID#_____
Medicare#_____ SS#_____

Name of Insured (if different from patient):_____
DOB of Insured_____ Insured SS#:_____
Employer of Insured: _____Address: _____

*Family Income_____□Week □Month □Year

**********The BELOW questions DO NOT have to be answered if the PATIENT is under 18 years of age**********

* Gender Identity: □ Male □ Female □Transgender Male/ Female to Male □ Transgender Female/ Male to Female □ Other □ Choose not to disclose

* Sexual Orientation: □Lesbian or gay □Straight(not Lesbian or gay) □Bisexual □Something else □Don't Know □Choose not to disclose

* Federal Mandate requires these to be asked

Consent and Release Form

I voluntarily consent to routine medical treatment by Rural Medical Services, Inc. for myself or the above named minor for whom I am parent or guardian. I understand that specific and separate consent will be requested from me prior to any non-routine, hazardous, or major treatment which is not of any emergency nature. I authorize the release of information from the medical records of the above named person only to the extent necessary to carry out the following purposes: fiscal and accounting use, consultation and referral, quality assurance, educational programs, and research programs maintaining confidentiality and previously approved by the Board of Directors of the Rural Medical Services, Inc. I declare that the information listed above is accurate and complete. I understand that I may be asked for evidence to verify the statement of income and family size if applying for sliding fee.

Parent or Guardian (if under 18):_____ Relationship to patient: _____
Printed Name

_____ Date: _____/_____/_____
Signature of Patient/Parent/Guardian

_____ Date: _____/_____/_____
Witness