Endwell Family Physicians LLP and the Walk-In at Endwell Family Physicians
PATIENT INFORMATION SHEET

Patient Name:_____ Male ___ Female___ DOB:_____

Race:_____ Ethnicity:_____ Language:_____

Single___ Married___ Widowed___ Divorced___ Primary Care Physician: _____

Address:_____ City/State:_____ Zip:_____

Home #:_____ Cell #*:_____

Work # :_____ Ok to call you at work? Yes ___ No___

Email*:_____

*By providing my cell number and email address, I understand and agree that Endwell Family Physicians may contact me by email and text for appointment reminders and scheduling information.

Employment: Employer:_____ Occupation:_____ FT___ PT___

Student: FT___ PT___ Retired: Yes ___ No___

Employer Address:_____ City/State:_____ Zip:_____

Responsible Party (Complete if parent or legal guardian. Please fill in two names, if applicable):

Name: _____ Relationship: _____ DOB:_____

Street: _____ City/State:_____ Zip:_____

Home Phone: _____ Cell Phone: _____

Name: _____ Relationship: _____ DOB:_____

Street: _____ City/State:_____ Zip:_____

Home Phone: _____ Cell Phone: _____

Emergency Contact: Name:_____ Relationship:_____

Phone:_____

STATEMENT OF AUTHORIZATION AND CONSENT:

I hereby authorize Endwell Family Physicians, LLP, to furnish information to insurance carriers with which it participates concerning my illness and treatment, and I assign to Endwell Family Physicians, LLP, all payments for medical services rendered to me or my dependents. I understand that I am responsible for any amount not covered by insurance.

I hereby authorize and consent to medical treatment that is deemed necessary or beneficial by the medical staff and/or designees of Endwell Family Physicians, LLP.

Patient or Parent/Guardian Signature: _____ Date:_____