Endwell Family Physicians LLP and the Walk-In at Endwell Family Physicians

PATIENT INFORMATION SHEET

Name:_____**Male___ Female___Single___Married___Widowed__Divorced___**

Race:_____ Ethnicity:_____ Language: _____

DOB:_____ 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, LLP 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: _____

Emergency Contact: Name:_____ Phone: _____

Relationship:_____

RESPONSIBLE PARTY (Complete if other than patient)

Name: _____ DOB: _____

Street: _____ City/State:_____ Zip: _____

Home Phone: _____ Cell Phone: _____

Primary Insurance:

Name of Insurance:_____ ID# _____

Group # _____ Person Who Carries Insurance _____

Secondary Insurance:

Name of Insurance:_____ ID# _____

Group # _____ Person Who Carries Insurance _____

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:** _____