ENDWELL FAMILY PHYSICIANS LLP AND THE EFP WALK -IN
PATIENT INFORMATION SHEET

Office use only: Account #_____

Patient Name: _____ DOB: _____

Gender at Birth: Male_____ Female_____ Preferred Gender: _____

Address: _____ City/State: _____ Zip: _____

Home #: _____Cell #: _____ Cell carrier (e.g., Verizon):_____

Email: _____

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

1) Name: _____ Relationship: _____

☐ Check box if address is same as above.

Address: _____ City/State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

2) Name: _____ Relationship: _____

☐ Check box if address is same as above.

Address: _____ City/State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

STATEMENT OF AUTHORIZATION AND CONSENT:

I hereby authorize Endwell Family Physicians, LLP, to furnish my personal health information to my insurance carrier/s, other health care providers, and other service providers for treatment, payment, or operations activities. 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 by the medical staff and/or designees of Endwell Family Physicians, LLP.

I understand that by providing my cell number and email address to Endwell Family Physicians, I agree that Endwell Family Physicians may contact me by email and text for things such as appointment reminders, scheduling information, feedback requests, and other news and information. We ask for your cell phone carrier because it is required to connect for a video visit and for pre-check in on your phone.

_____ _____

Patient or Parent/Guardian Signature **Date**