

Child

# Wills Valley Family Medicine

52 S Valley Ave Ste. B, PO BOX 890, Collinsville AL, 35961 Ph#256-524-3090 Fax 256-524-2885

## Patient Information

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ SS # \_\_\_\_\_ Sex: Male Female

Address (mailing) \_\_\_\_\_ Marital Status: \_\_\_\_\_

Phone number \_\_\_\_\_ Cell number \_\_\_\_\_ Pharmacy name \_\_\_\_\_

List Medicine Allergies \_\_\_\_\_ Email Address: \_\_\_\_\_

If you provide your email address you will be able to send messages to the doctor and call in medicines thru your email/ patient portal . If you have any questions please ask the front desk.

## Responsible Party: if self (skip to next section)

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Address \_\_\_\_\_

## In case of emergency

Name \_\_\_\_\_ Phone # \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Phone# \_\_\_\_\_ Relationship \_\_\_\_\_

## Authorization for the release of patient information

(Note if you check that you DO NOT want to release information to anyone we will not be able to give anyone scripts, appointments times or any medical information to anyone but you)

\_\_\_ I DO NOT wish to have medical information released to any other person than myself

\_\_\_ I DO wish to have medical information released to the following person (s)

Name: \_\_\_\_\_ Relationship \_\_\_\_\_

Name: \_\_\_\_\_ Relationship \_\_\_\_\_

Please understand that it may be necessary for us to disclose some or all of the information contained in your medical records to other physicians, nurses, and/or health care providers. All health care providers are required by law to maintain your patient confidentiality.

## Insurance Information

Primary Insurance \_\_\_\_\_ Policy # \_\_\_\_\_ Insured Birth Date \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Policy # \_\_\_\_\_ Insured Birth Date \_\_\_\_\_

I understand that Dr Koe or Nurse Practitioners at Wills Valley Family Medicine do not do long term pain management; they will do referrals to pain management if needed. If I decide to go ahead and see the doctor once I go back to triage room I will complete the visit and will be charged for a visit. We will not refund copays.

Signature \_\_\_\_\_ Date \_\_\_\_\_

If you are a cash patient stop by the front to see if you have to pay any test done at the clinic. You can get a discount if you cover the bill that same date of service. Lab services are more expensive if the lab bills you.