

Today's Date:	/ ,	/
9	 $\overline{}$	$\overline{}$

New Patient Questionnaire

Patient Information								
Legal Name Last		First	M.I.	Date of Birtl	h S.S. #:			
Address		City		State Zip Code				
Primary Phone N	umber		Driver's License	ise #:				
Who do you want as your new primary care provider/doctor?								
		e provider/doctor?						
Is there a family r	member that is cur	rently a patient here	9?					
Reason for appoi	ntment?							
Medical History/N	fain Medical Conc	erns:						
OFFICE USE ONLY								
□ Yes □ No								
Physician/Providers Signature Date								
Enter Date	Patient Returned	Gave to Provider	Received Back Fro	m Provider	Patient Appointment			

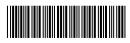


Today's Date:	/_	/

		}	Patient I	nfo	rmation	1					
Patient's Legal Last Name		First		M.I.] Sep	Date o	of Birth	Age
Patient's Social Security N	umber (If	not a minor):	Email							☐ Male	
Patient's Primary Phone N	umber			Seco	ndary Ph	one N	umber			<u> </u>	aic
Patient's Address (Permar	nent)		City	′			State	Zip	Code		
Patient's Address (Tempo	rary)		City	1			State	Zip	Code		
Patient's Employer Em	nployer A	ddress	City		State		Zip Code	Work Nu	umber	Occ	upation
Spouse/Parent's Name		Social Security	y Number	D	ate of Birt	th		Work Nu	umber	Осс	cupation
Spouse/Parent's Employe	r Employ	er Address	(City	;	State	Zip C	ode			
Spouses Address (if divorced or separated	Spouse	Address	C	City	;	State	Zip C	ode		Phone	Number
		tion for Re									1 16
I,							to receive m				my behalf:
NameAddress											
Phone #											
Relationship					elationship				• • • • • • • • • • • • • • • • • • • •		
Medical information may include test results such as labs, x-rays, and other tests and information from office visits. This will not include information concerning mental health or HIV testing, pregnancy, or gynecological issues. Any information requested must be known by the patient and he/she must be aware that the above-named person(s) are acquiring this information.											
Signature: (X)									ne:		
	ization	for Releas	se of Pro			alth	Informat	ion Up	_		
Signature		Date		SI	gnature				Da	te	
Authori	zation	for Agent t	to Cons	ent	to Med	ical	Treatme	nt of a	Mino	or	
I hereby authorize							e minor has		ntruste	d) to cc	nsent to
any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care of (name of minor) deemed advisable by a licensed physician and surgeon and provided											
by that physician or under made under Civil Code 25											
Signature: (X)					Da	ate:		Tim	ne:		
	С	onsent for	Treatm	ent	of a Mi	nor	Undates				
Signature		Date	TT Gatti		gnature		opaatoo		Da	te	
3					<u> </u>						
				l							
Cianatura of Witness				ot c			 -	ime			_
Signature of Witness			ט	ate			l	ime			
☐ Interpreter Used	ī	nterpreter ID:	# and/or Ir	ntern	reter Ser	vice I	Used		_	F-	702 (5/19)

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

I,	,
authorize, (Name)	(Date of birth) to disclose the following information
(Name of Institution)	
· ·	Geneseo ☐ Cambridge ☐ Kewanee ☐ Orion ☐ Port Byron on Receiving the Information)
for the purpose of	•
(Conti	inued Care, Legal Proceedings, Insurance Billing)
Medical records or other information regarding my tro	eatment, hospitalization, and/or outpatient care.
☐ History & Physical, Consultations	☐ Psychological Evaluation
☐ Operative Reports, Discharge Summary	☐ Psychological Examination
☐ Lab, X-Ray, EKG, EEG, Testing, etc.	☐ Entire Record
☐ Other	
This information is for the hospitalization and/or outp	patient visit from:to
	d may include information relating to sexually transmitted disease, n immunodeficiency virus (HIV), psychological or psychiatric buse, elderly abuse, rape, or adoption.
I understand this information may be re-disclosed by privacy regulations.	the person(s) receiving it and no longer protected by the federal
	ny time by giving written notice to the Health Information will not apply to information that has already been released in red by the Privacy regulations.
I understand that I may refuse to sign this authorization treatment, payment, or my eligibility for benefits.	on and that my refusal to sign will not affect my ability to obtain
I understand the medical record is protected under the the patient's written consent unless otherwise provided	e Federal Confidentiality Regulation and cannot be disclosed without d for in the regulations.
I understand that I may request to inspect the informa	tion to be released.
I understand this authorization shall automatically exp signing or on	pire without my expressed revocation 90 days from the date of
Signature of patient or Legal Representative	Date
If signed by Legal Representative, relationship	Signature of witness



RELEASE

F-2077 (10/17) Revised (5/20/19, 1/20, 2/20, 7/20, 9/21, 6/22)