Family Care Clinic of Ripley

Wanda Stroupe, DNP, FNP-BC

Whitney Walker, FNP-C Cynthia Haynes, NP-C

WELCOME TO OUR CLINIC!

TODAY'S DATE: _____

PLEASE PRINT

Patient's LEGAL Name: _____
First Middle Last

Home Address: _____ City, State, Zip _____
Primary Phone: ( ) _____ Secondary Phone: ( )_____
Work Phone: ( )_____ Occupation: _____
Email Address: _____ Social Security # _____
Date of Birth: _____ Gender: ☐Male ☐Female
Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed

Responsible Party: _____ Relationship: _____
Home Address: _____ City, State, Zip: _____
Primary Phone: ( ) _____Date of Birth: _____ SS#_____
Employer/Address: _____
Occupation: _____ Employer Phone: ( )_____

Race: (circle)
Am Indian Asian Black/African American Native Hawaiian/Pacific Islander White Declined

Ethnicity: (circle) Hispanic Non-Hispanic Declined

Preferred Language: (Circle) English Spanish Other: _____

Emergency Contact: _____ Relationship:_____
Phone Number: ( )_____

Release of Information:
Please note this only authorizes verbal communication. A written authorization from the patient or their personal representative is required to release any further information.

_____ _____ _____
Contact Name Relationship Phone

_____ _____ _____
Contact Name Relationship Phone

_____ _____
Patient Signature or Person Authorized to Sign **Date**

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Insurance Information:

Patient's Name: _____ Date: _____
First MI Last

Primary Insurance

Name of Insurance Company: _____
Address: _____ City, State, Zip: _____
Policy Holder: _____ Policy Holder Date of Birth: _____
Policy ID: _____ Group #: _____

Secondary Insurance

Name of Insurance Company: _____
Address: _____ City, State, Zip: _____
Policy Holder: _____ Policy Holder Date of Birth: _____
Policy ID: _____ Group #: _____

Our office will file primary and secondary insurance carriers for all reimbursable services. Please remember that you are responsible for all deductibles, co-pays, and non-covered service amounts.

General Consent to Treatment and Tests:

I _____ (Initial Here) am voluntarily seeking medical treatment. I consent to examination by the Physician, Nurse Practitioner, Nurse, and other healthcare professionals at this clinic. I also consent to any medical procedures, x-rays, lab test(s), or other health care services ordered by my healthcare team. I understand that I may refuse specific treatments or procedures by informing my healthcare team.

Release of Information:

I authorize this clinic to release any medical information necessary to process my claim.

Assignment of Insurance Benefits and Acceptance of Financial Responsibility:

I authorize payment directly to the clinic. I understand and agree that if any part of my account is not paid by insurance, I am financially responsible.

_____ _____

Patient Signature or Person Authorized to Sign **Date**