Rochester Family Medicine PC

New Patient Information for Walk-in / Urgent Care Visit

Patient Information:

Patient Last Name: _____ First Name: _____ MI. _____

SSN: _____ Street Address: _____

City: _____ State: _____ Zip-Code _____

Date of birth _____ Sex _____ Marital Status _____

Cellular Phone _____ Home Phone _____

Reason for Visit: _____

Emergency Contact: _____ Phone _____ Relationship: _____

Primary Care Doctor _____ Phone _____

Pharmacy Information:

Preferred Pharmacy Name: _____ Telephone Number: _____

Pharmacy Address (at least City, State) _____

Insurance Information:

Insurance Company Name _____ Effective date: _____

Insurance ID/ contract number _____ Group # _____

Primary Insurance Subscriber:

Subscriber Last Name _____ First name _____

MI. _____ SSN _____ Date of birth _____

Street address _____ City _____

State _____ Zip-Code _____ Home phone _____

Cell Phone _____ Relationship between Subscriber & Patient _____

Persons Authorized to Receive Information:

Health Information Rochester Family Medicine PC collects or receives about you may be disclosed to the following persons. Examples: Spouse, Children, Friends, Relatives.

- ☐ I authorize _____ to receive all heath information about treatment and /or information pertinent to my healthcare provided at Rochester Family Medicine PC.
- ☐ I DO NOT authorize medical information to be disclosed to any parties except me as the patient.

Patient Medical History:

_____Cancer	_____Heart Disease	_____Thyroid
_____Hypertension (High Blood Pressure)	_____Stroke	_____High Cholesterol
_____COPD	_____Heart Attack	_____Anxiety
_____Diabetes Type 1 / Type2	_____Seizures	_____STD's
_____Asthma	_____Allergies	_____Depression

Other, please explain: _____
_____

Current Medications: (Please provide any lists you already have)

_____ Dose: _____
_____ Dose: _____
_____ Dose: _____
_____ Dose: _____

Known Drug Allergies: _____
_____

I certify that the information provided is correct to the best of my knowledge. I will not hold Rochester Family Medicine PC, its health providers, or its employees responsible for any errors or omissions that I may have made in completing the information on this form. The above information is true with active coverage benefits. I understand it my responsibility to verify what my insurances benefits are with my insurance company including routine physical coverage, co-insurance, deductible, and any out-of-pocket expense. I agree to update the above information with office upon any changes. I agree to pay at the time of service for any co-payments due and promptly upon receipt of a bill for any out-of-pocket expenses that may be my responsibility. I authorize my insurance company to remit payment to Rochester Family Medicine PC.

Print Patient Name | Date | Witness

Signature of Patient (or Guardian if patient is under 18 years of age) | Relationship to Patient