WALK-IN HEALTH CLINIC INCORPORATED

Date _____-_____-_____

Last Name _____ First _____ Middle _____ Male☐ Female☐

DOB _____-_____-_____ Age_____ SSN _____-_____-_____ Do you prefer to go by any other name? _____

Mailing address _____ Apt _____ City _____ State _____ Zip_____

Home Phone _____ Cell Phone _____ Work Phone_____

IMPORTANT! Do we have permission to leave a detailed message with lab and x-ray results? ☐**Yes** ☐**No** At which #? ☐**Home Phone** ☐**Cell Phone**

Employer _____ Full time☐ Part time☐ Retired☐ Student (full time)☐ Student (part time)☐

Single☐ Married☐ Divorced☐ Legally Separated☐ Widowed☐ Spouse name _____ Phone _____

Emergency Contact _____ Phone _____

Medical History (for additional space use backside of form)

Prescription medications _____

Allergies/History _____

Primary Care Provider _____ City _____ State _____

Do you smoke cigarettes? Yes☐ No☐ If yes, how often? _____ **Last Tetanus Update**_____

Do you drink alcohol? Yes☐ No☐ If yes, how often? _____

Insurance Information

Primary Insurance Company_____ Identification # _____ Group# _____

Policy Holder _____ Birthdate _____-_____-_____ Relation to patient _____

Mailing address _____ Apt _____ City _____ State _____ Zip_____

Secondary/Supplemental Insurance _____ Identification # _____ Group# _____

Policy Holder _____ Birthdate _____-_____-_____ Relation to patient _____

Mailing address _____ Apt _____ City _____ State _____ Zip_____

Notice of Privacy Practices Acknowledgment

The Walk-In Health Clinic has a responsibility to protect the privacy of your health care information and to provide a Notice of Privacy Practices that describes how your health care information may be used and disclosed, how you can access your health care information, and whom to contact if you have questions, concerns, or complaints.

We may change the Notice of Privacy Practices at any time, and you may contact the **Office Administrator** at **360-734-2330** to obtain a current copy of the Notice of Privacy Practices or to ask questions.

By my signature below, I agree that I have received the Notice of Privacy Practices of the Walk-In Health Clinic.

_____

Printed name of patient

_____

Patient or legally authorized individual's signature Date

_____

Printed name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative)

HOW DID YOU HEAR ABOUT THIS CLINIC: ☐ PHONE BOOK ☐ INTERNET ☐ FRIEND/FAMILY ☐ EMPLOYER ☐ PHYSICIAN ☐ OTHER

2220 CORNWALL AVENUE BELLINGHAM, WA 98225
CALL 360-734-2330 FAX 360-733-3886