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**Patient Information Sheet**

**Today’s Date:\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_**

**Full First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Nickname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_**

**Mailing Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ZIP:\_\_\_\_\_\_\_\_\_\_**

**Physical Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ZIP:\_\_\_\_\_\_\_\_\_\_**

**Cell Phone: (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Social Security # (Last 4 Digits): X X X – X X -- \_\_\_ \_\_\_ \_\_\_ \_\_\_**

**May we leave a voice message: YES\_\_\_\_\_\_ NO\_\_\_\_\_\_\_**

**May we send a text message: YES\_\_\_\_\_\_ NO\_\_\_\_\_\_\_**

**May we send an email: YES\_\_\_\_\_\_ NO\_\_\_\_\_\_\_**

**Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_@\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Occupation:­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EMERGENCY CONTACT:**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone: (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DO YOU CURRENTLY HAVE:**

**1) Health Insurance: YES\_\_\_\_\_\_ NO\_\_\_\_\_\_\_ \*IF YES, Does it cover Mental Health? YES\_\_\_\_\_\_ NO\_\_\_\_\_\_\_**

**2) Medicare or Medicaid: YES\_\_\_\_\_\_ NO\_\_\_\_\_\_\_ \*If YES, please sign waiver regarding reimbursement**

**\*ALLERGIES:**

**Do you have Allergies? YES\_\_\_\_\_\_ NO\_\_\_\_\_\_\_**

**Please list any Allergies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Patient/Guardian: X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Printed Name of Patient/Guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_**

**ACKNOWLEDGEMENT OF RECEIVING PRIVACY POLICY AND AUTHORIZATION TO USE & DISCLOSE PROTECTED HEALTH INFORMATION**

By signing below, I acknowledge that I have received a copy of the Privacy Policy of Island Health & Wellness Center and that I authorize Island Health & Wellness Center to use and disclose my protected health information for the purposes of treatment, payment and healthcare operations, as described in the Privacy Policy.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Signature of Patient or Authorized Representative) (Date)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Print Name of Patient or Authorized Representative) (Relationship to Patient)

**GENERAL CONSENT FOR TREATMENT**

I request and authorize health care services by my provider and his/her designee(s), at Island Health & Wellness Center, as my provider may deem advisable and in my best interest. This may include routine diagnostic, medication prescription/administration and laboratory procedures. I understand that my provider and designee(s) will inform me of the services being provided and discuss the reason/rationale and need for what is being provided. I understand that I have the right to refuse services and/or treatment, even against medical advice.

I understand that excluding emergency or extraordinary circumstances, no substantial procedure will be performed without providing me an opportunity to accept or decline that procedure. Informed consent means the medical provider must disclose information to me including expected benefits and risks of a particular procedure and/or treatment.

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(Signature of Patient or Authorized Representative) (Date)

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(Print Name of Patient or Authorized Representative) (Relationship to Patient)