# Gila Valley Clinic, P.C.
## Patient Information

**Patient Information**: *(Please print clearly)*

Patient's name:______________________________ S.S. number*(Required)*:_______________

Mailing Address:______________________ City & State:_________________ Zip:_______

Street Address:______________________ City & State:_________________ Zip:_______

Home Phone # (   )______________ Cell Phone # (   ) __________________

Date of Birth:_______________ Email Address: ___________________________________

Marital Status: S M W D Sep   Sex: M F   Student: YES NO   Age:___________

***Pharmacy:___________________________ Phone Number(if not local):_______________**

***Previous Physician's Name:__________________________ *Date of last visit:___________**

***Reason for leaving:_________________________________________________________**

**Ethnicity:** Hispanic: YES NO **Race:** Am.Indian/Alaska Native * Asian * Black/African American * Native Hawaiian * White

Occupation:___________________ Employer:___________________ Bus. Phone:__________

Employers Address:_________________________ City & State:_______________ Zip:______

Spouse's Name:_________________________ Phone Number #:(   )_______________

**Parent's Information for Patients Under the Age of 18** *(Please print clearly)*

Mother's Name:_________________________ Father's Name______________________

Mother's Phone number:___________________ Father's Phone Number: ________________

Mother's SSN:_____________ DOB:_______ Father's SSN:________________ DOB:_______

**Insurance Information **COPIES OF INSURANCE CARDS ARE REQUIRED BEFORE BEING SEEN****

**(1) - Primary Insurance**:_____________________________ Member ID#:____________________

**(2) - Secondary Insurance**:___________________________ Member ID#:____________________

**Emergency Contact Information** *(Please print clearly)*

Person to contact out of the home:_____________________________________________

Relationship to person:_________________________ Home Phone #: (   )____________

**Consent and Authorization & HIPPA Privacy Policy**

I hearby give my consent for Gila Valley Clinic to use or disclose my personal health information only for three areas which are treatment, payment, or health care operations. I understand that I have the right to review the provider's privacy notice, to request restrictions and to revoke this consent at anytime.

I authorize Gila Valley Clinic to release my medical information that is needed for further treatment, in order to obtain payment or for health care operations . I understand that this authorization allows the release of my medical information to another party only for further treatment, payment or health care operations. This consent and authorization is valid for Gila Valley Clinic only and does not permit any other entity to release the information supplied to them by Gila Valley Clinic. I understand that this authorization is valid as long as I am a patient of Gila Valley Clinic. I also understand that I have the right to revoke this authorization at any time by written request to Gila Valley Clinic.

Date:_______________ Signature:_____________________________________________