Clifton Comprehensive Medical Center

Confidential Patient Information

Today's Date:

Patient Information			
Name		☐ Male ☐ Female	
Address		**City, State**	**Zip Code**
Home Phone	**Cell Phone**	**Work Phone**	**Email**
Birth Date	**Age**	**Is today's visit related to: work or accident**	
Preferred Way To Contact You: ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email *By making a contact selection you are giving us permission to contact you.			
Employer/School			
Emergency Contact		**Relationship**	**Phone**
Marital Status		**Pharmacy Name and Address**	

Financial Responsibility			
Person Responsible for Account		**Relationship to Patient**	
Address (if different)		**City, State**	**Zip Code**
Home Phone	**Cell Phone**	**Work Phone**	**Employer**
Birth Date	**SS#**	☐ Male ☐ Female	

Primary Insurance		
Insurance Company	**Phone #**	
Address	**City, State**	**Zip Code**
Subscriber Name	**ID#**	**Group #**
Birth Date	**SS#**	

Secondary Insurance		
Insurance Company	**Phone #**	
Address	**City, State**	**Zip Code**
Subscriber Name	**ID#**	**Group #**
Birth Date	**SS#**	

Consent to Treatment

☐ I am the patient or ☐ I am the parent/guardian of the patient or ☐ Other Relationship _____

I hereby authorize such medical care, treatment, and diagnostic tests as may be recommended and understand there is no warranty or guarantee of result or cure. This consent will remain in effect until I withdraw my consent in writing.

Signature of Patient/Parent/Guardian: **Date**:

A photocopy or faxed copy of these authorizations shall be deemed as valid as the original