Appointment Date:	Appointment Time:	Appointment Doctor:

Patient Name: Sex: M F	Email Address: Account No	
Patient Address, street/city/state/zip:	DOB:	Social security no:
Race: O AmericanIndian/AlaskaNative O Asian O NativeHawaiian/Other Pacific O White O Black/AfricanAmerican O Hispanic O Refuse to Report O Other Race	**Language:** O English O Spanish O Other	**Ethnicity:** O Hispanic/LatinAmerican O NonHispanic/NonLatinAmerican O Refuse to Report
Primary contact Home phone:	Cell Phone: «ptCell»	Work Phone:
Primary Insurance Info:	Subscriber No/ Group No: /	
Subscriber:	Emergency Contact Name/Number/Relation:	

- **If you wish to give Parental Permission to treat your Minor Children:**

I hereby request and authorize Conifer Medical Center to deliver medical care to my dependent child in the event that I am unable to be reached within a reasonable period of time. All reasonable efforts will be made to contact me prior to treating my child.

Signature: _____ Date: _____Valid until revoked in writing

- **Consent to Share Medical Information:**

☐ I do not wish to share my information with anyone.

☐ I give my consent to share my medical information with the following individuals:

Names: _____

- **Voice message authorization:** I authorize CMC to leave voice messages at this number:

☐ HOME ☐ CELL ☐ WORK ☐ TEXT

- **Authorizations**:

- I verify that all information contained on this form is true and correct to the best of my knowledge and belief.
- I have reviewed the notice of privacy and payment practices of Conifer Medical Center.
- Copays for ALL visits are due at time of service; otherwise a service fee of $15 will apply.
- No Show appointments will be charged $50. You must call 12 hours in advance if you are unable to keep your appointment.
- ALL collection fees including a 40% charge, reasonable attorney fees, court costs and returned check fees are the responsibility of the account guarantor.
- Conifer Medical Center will bill an after-hours charge for appointments Monday-Friday 5:00-6:00 pm and on weekends.
- Verifying your plan coverage and benefits is your responsibility.

Responsible Party Signature: _____ Date: _____