Today's Date: _____

US FAMILY HEALTH PLAN
At Mitchel Field

Patient Information

Patient's Name _____ _____ _____
Last Name First Name Initial

Address _____ Apt Number _____

City _____ State _____ Zip _____ Rank _____

Male _____ Female _____ Age _____ Date of Birth _____ SS # _____

Telephone _____ _____ _____
Home Work Cell

E-Mail Address _____ Occupation _____ Employed _____ Retired _____

Language Spoken/Special Needs _____

Emergency Contact Information

Name _____ _____ _____
Last Name First Name Relationship

Telephone _____ _____ _____
Home Work Cell

Insurance Information

Insurance _____ ID # _____

Guarantor's Name _____ _____ _____
Last Name First Name Relationship

Address _____ Apt Number _____

City _____ State _____ Zip _____ SS# _____

Telephone _____ _____ _____
Home Work Cell

Do you have other health insurance? Yes _____ No _____ If Yes, please provide the following information:

_____ _____
Name of Insurance ID #

_____ _____
Name of Guarantor Guarantor SS #

Authorization for Treatment

I, the patient named or parent or guardian of the named patient, hereby authorize and request the Mitchel Field Family Health Center, its physicians, nursing staff and other Health Center personnel to provide such medical care and administer such diagnostic, radiological and/or therapeutic procedures and treatments, including, but not limited to, the administration of pharmaceutical products, routine blood and urine tests, injections and intravenous medications or therapeutic solutions as in the judgment of the physicians in attendance are deemed necessary and advisable for my (the patient's) care or, for obstetrical patients, for the care of my (the patient's) newborn. These include all diagnostic tests and procedures, including, but not limited to the diagnostic x-ray, pharmaceutical products or medications, and drawing of blood and other miscellaneous related tests and procedures as may be warranted by my (the Patient's) condition. I give the Mitchel Field Family Health Center the authority to dispose of specimens taken for laboratory and pathology examination.

_____ _____
Signature of Patient or Authorized Representative Date

_____ _____
Print Name Relationship to Patient