

Today's Date: \_\_\_\_\_



**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 Bay Ridge 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 Bay Ridge 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