**PATIENT INFORMATION** **MRN** ________________

Last Name ____________________ First Name____________________ Middle Initial_________

Birthdate _______/________/________ Sex: Male Female Other Social Security Number ____________________

Mailing Address ____________________ Apt/Ste# ______________

City ____________________ State __________ Zip _____________ E-Mail ____________________

Preferred Phone ____________________ Alt. Phone ____________________

Primary Care Physician Name & Location ____________________ ____________________

**ALLOWING ACCESS TO YOUR MEDICAL INFORMATION**

I consent to allow secure access to my Electronic Health Record to the following people: (Does not include medical professionals involved in your coordination of care). Communication may include phone access, delivering lab results verbally or in person, discussing my medical condition, pick up copies of electronic medical record, and/or my appointment information. (This information will remain current unless you alert us of a change)

| Name | Relationship | Phone | Date |
|---|---|---|---|
| ____________ | ____________ | ____________ | ________ |
| ____________ | ____________ | ____________ | ________ |

I consent to allow providers and staff at NWGI/NWEC to leave a detailed message at the following phone number and/or email. I understand this may include information regarding appointments as well as personal medical or financial information related to my medical care.

Phone Number where messages can be left ____________________ E-Mail ____________________ Date ______________

**INSURANCE**

Primary ____________________ ID # ____________________ Secondary ____________________ ID # _____________

Responsible Party Information (complete if patient under 18 OR spouse or parent provides insurance)

Last Name ____________________ First Name ____________________Middle Initial __________ DOB ___________

Address ____________________ APT/STE# _______ City____________________ State ___________ Zip________

Preferred Phone ____________________ Alt. Phone____________________ Employer ____________________

Relationship to patient ____________________

If we are billing an insurance carrier the printed name on the card must match EXACTLY to what is above.

**Patient Signature** ____________________ **Date**____________________