Welcome to **Three Rivers Medical Clinic** Please print legibly. | Date

PATIENT INFORMATION

Patient's Legal Name	Date of Birth	Social Security Number

Previous Name(s)	Gender

Mailing Address	City	State	Zip

Home Phone	Mobile Phone	Other Phone

Email Address	Employer	Employer Phone

May test results be left in a voicemail on:
Home phone? □ Yes □ No Mobile phone? □ Yes □ No Other phone? □ Yes □ No Work phone? □ Yes □ No
May test results be sent in an email or through a patient web portal? □ Yes □ No

Spouse's/Partner's Name	Phone(s)	May we share your health information: With this person? □ Yes □ No On this person's voicemail? □ Yes □ No

Emergency Contact's Name	Phone(s)	May we share your health information: With this person? □ Yes □ No On this person's voicemail? □ Yes □ No

RESPONSIBLE PARTY (Guarantor)

Complete this section as the guarantor only if someone other than the patient is financially responsible.

Name	Date of Birth	Social Security Number

Mailing Address	City	State	Zip

Home Phone	Mobile Phone	Other Phone

Relationship to Patient	Employer	Employer Phone

INSURANCE INFORMATION

Complete this section. Please provide insurance card(s) at time of visit.

Primary Insurance	Group Number	Policy ID Number

Policyholder Name	Policyholder's Date of Birth	Patient Relationship to Policyholder □ Self □ Spouse □ Child □ Other

Secondary/Supplemental Insurance	Group Number	Policy ID Number

Policyholder Name	Policyholder's Date of Birth	Patient Relationship to Policyholder □ Self □ Spouse □ Child □ Other

WORKER'S COMPENSATION

Is this a work-related injury? □ Yes □ No	Date of Injury	Is this a work-related injury NOT being filed with Work Comp? □ Yes □ No

Was the injury reported to employer? □ Yes □ No	Supervisor	May we share claim-related health information with employer? □ Yes □ No

Worker's Compensation Insurance Carrier