Pineapple Health
PATIENT INFORMATION

Name:

☐ Yes, I am going to read Foothills Family Medicine's Office Policies

Social Security Number (SSN): Date of Birth:

Home Address:

City: State: Zip:

Mailing Address (if different from above):

City: State: Zip:

Daytime Phone: Evening Phone:

Email Address:

Sex: ☐ Male ☐ Female

Marital Spouse: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Seperated

Spouse's Name: Healthcare Proxy: ☐ Yes ☐ No

Referring Physician's Name & Address:

City: State: Zip:

EMPLOYMENT INFORMATION

Employed: ☐ Yes ☐ No Occupation:

Employer (Parent's employer if minor):

Employer's Address:

City: State: Zip:

Spouse's Employer:

Spouse's Employer's Address:

City: State: Zip:

Phone: Spouse's SSN:

RESPONSIBLE PARTY INFORMATION

Person Responsible for Medical Expenses:

Relationship to Patient: Phone:

Spouse's Employer's Address:

City: State: Zip

PRIMARY INSURANCE INFORMATION

Insurance Company:

Policy Number:

Medicare Number:

Medicaid Number:

Subscriber's name:

Subscriber's Relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Address of Insurance Company:

City: State: Zip:

SECONDARY INSURANCE INFORMATION

Insurance Company:

Policy Number:

Medicare Number:

Medicaid Number:

Subscriber's name:

Subscriber's Relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Address of Insurance Company:

City: State: Zip:

We accept most insurance. However, participation may vary by plan and insurance company so please check with your insurance plan administrator. With regard to the Affordable Care Act (Obamacare), it is your responsibility to contact your insurance company before your appointment to make sure we accept your specific plan.

EMERGENCY INFORMATION

Person to Contact in Case of Emergency, Other than Spouse:

Relationship to Patient: Phone:

Address:

City: State: Zip:

AUTHORIZATION

I authorize the release of any medical information necessary to process claims for payment. I permit a copy of this authorization to be used in place of the original. I authorize direct payment of benefits to the physician for services rendered. I realize I am responsible for payment of charges not covered by insurance. I certify that the information I have reported with regard to my insurance coverage is correct.

Patient's Signature: _____ Date:

Spouse's Signature: _____ Date:

GENERAL CONSENT FOR MEDICAL TREATMENT

I understand that I have the right to make informed decisions about my health care treatment. I understand that Foothills Family Medicine-Rejenesis specializes in Integrative and Preventive Medicine. I further understand that Dr. Kevin Chan is a recognized specialist in this area. I agree to have Dr. Kevin Chan and his providers and staff do tests and treatments they believe are needed for my care, including my annual physical. These may include but not limited to vital signs, ekgs, spirometries, x-rays, scans, expanded lab tests, allergy testing, lifestyle modifications, physical therapies, acupuncture, medications, hormone replacement therapies, as well as nutritional and herbal supplementations. I know other treatments or tests that may have more risks will be explained to me so I can give informed consent for them if I need them.

Name: Date:

Witness (Optional):