RANA'S FAMILY MEDICAL CLINIC

810 HWY 2 N
WILBURTON, OK 74578
Phone: 918-465-0170 Fax: 918-465-4830

PATIENT INFORMATION

First Name	Middle	Last Name	Birth Date	Age	Gender

Address: ______________________________ **City/State/Zip:** ______________________________

Home Phone: ___________________ **Cell Phone:** _________________ **SSN:** ________________

E-mail address: ____

Employer: _________________________________ **Occupation:** __________________________

The Federal Government requires this information for Electronic Medical Records. You have the right to choose "declined".

***Race*:**
- □ White / Caucasian
- □ Black / African American
- □ Asian
- □ Native Hawaiian / Other Pacific Islander
- □ American Indian / Alaska Native
- □ Other
- □ Declined / Unknown

***Ethnicity*:**
- □ Spanish / Hispanic Origin
- □ Not of Spanish / Hispanic Origin
- □ Declined / Unknown

Primary Language: ___________________________

Marital Status: ______________________________

Person/guarantor responsible for payment of services (if different from patient)

First Name	Middle	Last Name	Birth Date	Age

Address _____________________________________ **City/State/Zip** ______________________

Home Phone: ___________________ **Cell Phone:** ________________ **Work Phone:** ____________

Employer: ______________________________ **Occupation:** ________________________

Emergency Contact (not within the same household)

Name	Emergency Number (s)	Relationship to patient

I hereby authorize Rana's Family Medical Clinic to release any medical information required in the course of examination and treatment. I authorize payment directly to Rana's Family Medical Clinic any charges due for services rendered. I recognize and accept responsibility for services rendered regardless of insurance coverage. The medical providers will perform / order only those tests medically necessary. It is my responsibility to determine if my insurance will cover these tests. I authorize this office to use FAX and EMAIL as a means of rapid communication with other physician's offices, pharmacies, laboratories, and insurance companies that are pertinent to my care. I understand that this office follows HIPAA protocols and protects my privacy as a patient. I have read and understand the above statements.

Signature: ____ **Date:** ______________