GRACE MEDICAL CLINIC

Date: _____

Please help us serve you better by taking a few minutes to complete this form.

Last Name: _____ First Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

(We will only use your email address to send out clinic information/updates, and appointment confirmation. No personal health information will be sent via email.)

Date of Birth: _____ Age: _____ Marital Status: ____S____M____D____W

Employer Name: _____ Work Phone: _____

Referred by: _____ Family Physician: _____

Emergency Contact Name: _____ Phone: _____

Relationship to patient: _____

If unable to reach me:

[ ] please leave a message asking me to return your call

[ ] you may call emergency contact listed above

Medical History (check all that apply):

__ Diabetes
__ Constipation or Diarrhea
__ Heart Disease
__ Chronic Pain
__ Pneumonia
__ Depression
__ Cancer
__ HIV
__ Liver Disease
__ Chest Pain
__ High Cholesterol
__ Sinus Disease or Allergies
__ Kidney Disease
__ Anxiety
__ Parkinsons
__ Painful Urination
__ Thyroid Disease
__ Asthma
__ High Blood Pressure
__ Headaches
__ Heart Attack
__ Insomnia
__ Seizures
__ Arthritis
__ Tuberculosis
__ Stomach Ulcer or Reflux

Drug or food allergies (please list):

_____

Current Medications (please list Name, Dose & How Often):

_____

GRACE MEDICAL CLINIC

Medical Information Release Form

(HIPAA Release Form)

Name: _____ Date of Birth: ____/____/____

Release of Information

[ ] I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

[ ] Spouse _____

[ ] Children _____

[ ] Other _____

[ ] Information is not to be released to anyone.

The Release of Information will remain in effect until terminated by me in writing.

Signed: _____ Date: ____ /____/____

Witness: _____ Date: ____/____/____

16 Mills Avenue, Unit 3, Greenville, SC 29605 Phone: 864-232-1685 Fax: 864-232-1686

Consent to Treatment

By Signing this form below, I _____ (Print First and Last Name) give my consent to be treated by the medical professionals of **Grace Medical Clinic**. I am aware that my medical care provider needs medical facts about my health history. I understand that **Grace Medical Clinic** treatments may include: Lab Tests, Screening Tests, Diagnostic Tests, and Routine Exams. I am aware that all patients have the right to make final decisions regarding their treatment and care planning.

Financial Policy – The healthcare providers of **Grace Medical Clinic** is not responsible for taking care of my personal items. This includes items such as jewelry, eyeglasses, hearing aids, dentures, clothing, and cell phones. I know that I must take care of my personal items and that it is my responsibility to not leave them unattended.

Acknowledgement - I prove with my signature below that:

- The facts that I have given to **Grace Medical Clinic** are correct.
- I have read and understand all the facts stated above.
- I have had the chance to ask questions about the facts in this form, and all of my questions have been answered.
- I know that I will be asked to sign this form again if I am still a **Grace Medical Clinic** patient in one year.
- I know that I may withdraw this form by writing to the **Grace Medical Clinic.**

_____ _____

Patient signature or Responsible party Date

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