MEMBER PLUS FAMILY HEALTH

Personalized Health Care for Bainbridge Island

# APPLICATION FOR MEDICAL CARE

Legal Name_____

Last name First Middle Nickname

Address_____

Phone (H) _____(C)_____(Wk)_____

Email address _____

Social Security #_____-_____-_____ Birthdate_____ Preferred Pharmacy_____

May leave detailed health information: (H) ☐ (C) ☐ (Wk) ☐ (Email) ☐

Race_____ Ethnicity /Hispanic/Latino (Y) ☐ (N) ☐ Preferred Lang._____

Do you have any of the following:

Living Will (Y) ☐ (N) ☐ POLST (Y) ☐ (N) ☐ Health Directive (Y) ☐ (N) ☐

Primary Insurance_____Id#_____Group#_____

Subscriber Name_____ Birthdate_____

Employer_____ Social Security #_____-_____-_____

Secondary Insurance_____Id#_____Group#_____

Subscriber Name_____ Birthdate_____

Emergency Contact:

Name_____ Phone _____ Relationship _____

SEE HIPAA CONSENT FORM for consent to share personal health information with other person(s).

This information will be kept in my medical record and will be abided by until revoked by me in writing. It is my responsibility to notify Member Plus Family Health of any change to the above information.
If patient is a minor, signature of guardian is required and indicates consent for treatment in this office.

Authorized Signature _____ Date_____