RIFE & ASSOCIATES
FAMILY HEALTH CARE

Patient Name: _____ Date of Birth: _____ Age: ____ Email: _____

Address: _____ City/State/Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Sex: ____ Social Security: _____ Marital Status: S M W D Sep Spouse: _____

Check if ok to leave message at:
__ Home __ Cell __ Work

How do you prefer to be contacted for your appointment reminder? (Check all you'd prefer)
__ Phone __ Text __ Patient Portal

Race: (Please Circle One) American Indian, Alaskan, Asian, African American, Caucasian, Hawaiian-Pacific Islander, Latino

Ethnicity: (Please Circle One) Hispanic or Non-Hispanic **Preferred Language**: _____

Preferred Pharmacy: _____ Location: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Responsible Party Name: _____ Date of Birth:_____

Address: _____ City/State/Zip_____

Home Phone: _____ Work Phone: _____ Relationship: _____

How did you hear about us? Thank you for your feedback!
__ Website __ Billboard __ Radio __Newspaper __Bus Ad __Google Search __Family/Friend
__Insurance __ Facebook __ Instagram __Yelp __Google Ad __Other: _____

Assignment of Insurance Benefits: I hereby authorize direct insurance carrier payment of surgical/medical benefits to Dr. Rife and Associates Family Health Care, S.C. for services rendered by her/him in person or under her/his supervision. I understand that I am financially responsible for any balance not covered by my insurance
Authorization to Release Information: I hereby authorized Dr. Rife and Associates Family Health Care S.C. to release any medical or incidental information that may be necessary for either medical care or in processing application for financial benefits.
Medicare/Medicaid: I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request payment of authorized benefits be made on my behalf.
Acknowledgement/acceptance of No Show/24 Hour Cancellation: I hereby agree to the terms that if I am not able to keep my schedule appointment and do not call to cancel my appointment with 24 hours prior to my appointment I will be charged a no show/24 hr. cancellation fee for that missed appointment. **A photo copy of these assignments shall be valid as the original.**

_____ _____
Patient Signature Date

_____
Relationship (if other than patient)