Abundant Family Practice
246 E 1260 N Logan UT 84341-7501

Patient Forms

Basic Information

Full Name ______________________________
First Middle Last Suffix

Sex ○ Male ○ Female ○ Unknown

Date of Birth ____ / ____ / ____

Primary Phone ○ Home ○ Mobile ○ Work

Phone Number ______________

Email ______________

Social Security Number ______________

Address Line 1 ______________

Address Line 2 ______________

City ______________

State ______ Zip ______

Marital Status ______________

Maiden Last ______________

Driver's License State ______________

Driver's License # ______________

Demographics

Sexual Orientation ______________

Gender Identity ______________

Hispanic or Latino? ○ Yes ○ No ○ Decline to Specify

Ethnicity ______________

Race ______________

Language ______________

Emergency Contact

Relationship to Contact ______________

Full Name ______________________________
First Middle Last

Primary Phone ○ Home ○ Mobile ○ Work

Phone Number ______________

Email ______________

Address Line 1 ______________

Address Line 2 ______________

City ______________

State ______ Zip ______

Financial Information

Responsible Party

Who will be financially responsible for you? ◯ Myself ◯ Someone else

If you chose "Someone Else", please fill out the following:

Relationship to Contact

Full Name
First Middle Last

Primary Phone ◯ Home ◯ Mobile ◯ Work Phone Number

Method of Payment

What will be your method of payment? ◯ Insurance ◯ Self-Pay

If you chose "Insurance", please fill out the following:

PRIMARY INSURANCE POLICY

Insurance Company Policy Number

Insurance Plan Insurance Phone Number

Group Number

Insurance Company Address Address Line 2

City State Zip

Relationship to Primary Policy Holder

If you are not the primary policy holder, please fill out the following:

Full Name
First Middle Last

Sex ◯ Male ◯ Female ◯ Unknown Date of Birth / /

Policy ID Number Social Security Number

Policy Holder Address Address Line 2

City State Zip

If you are unable to provide your insurance information, please provide a reason before continuing.

SECONDARY INSURANCE POLICY

If you do not have a secondary insurance policy, you can leave this blank.

Insurance Company ______ **Policy Number** ______

Insurance Plan ______ **Insurance Phone Number** ______

Group Number ______

Insurance Company Address ______ **Address Line 2** ______

City ______ **State** ______ **Zip** ______

Relationship to Secondary Policy Holder ______

If you are not the secondary policy holder, please fill out the following:

Full Name ______
First Middle Last

Sex ○ Male ○ Female ○ Unknown **Date of Birth** ___/___/___

Insurance ID Number ______ **Social Security Number** ______

Policy Holder Address ______ **Address Line 2** ______

City ______ **State** ______ **Zip** ______

Additional Information

Please list your preferred pharmacies in order of preference

Pharmacy Name	Pharmacy Address

How did you hear about us? ______

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I, the undersigned, hereby authorize **Abundant Family Practice** and it's affiliates the release of medical/health/psychological information of:

Name (print):		Birthdate:	
Address:		City, State, Zip:	
Home Phone:			

Initial One:	Professional/Clinic/Person:	
To release information to:	Address:	
— To receive information from:	City, State Zip:	
— To exchange information with:	Phone:	
—	Fax:	

Please provide any information available whether written or verbal with respect to any psychological testing, reports, academic information, medical history, physical examinations/evaluations, consultation reports, and any treatment or programs prescribed.

With the following limitations or exclusions:

Important:

- You may revoke this authorization at any time by written request. Obviously, the revocation can't apply to information already released.
- There may be charges associated with services rendered to fulfill this release of information request.
- Your treatment is not conditional on signing this authorization.
- You are entitled to a copy of this authorization upon request.
- This authorization will expire one year from the date of your signature below.

Person Authorized to Consent: ____________________ **Date:** __________

Signature of Authorized Person: ____________________ **Date:** __________