CASCADE
DIRECT CARE

Patient Information:

Patient Name:	DOB:	Gender:
Previous/Nick Name:	Social Security #:	
Mailing Address:		
Home Phone:	Cell Number	
Work Phone:	Email Address	

Employer Information	
Employer Name:	
Employer Address:	
Employer Phone:	OK to Leave Messages at Work?

Emergency Contact Name:	Relationship:
Address:	
Home Phone:	Work/Cell:

Insurance Information (for hospital studies, specialist referrals, etc.)	
Insurance Company & Address:	
ID#	Group #
Subscriber Name, Address, DOB, and relationship to patient:	

How did you hear about Cascade Direct Care?

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Current Medical Information & History

List any medications that you take including over-the-counter medications:

Allergies:

Ongoing Medical Issues:

Current Specialists:

Do you smoke? If so, how much and how long?

Do you use alcohol? If so, how much and how long?

Do you use illicit drugs? **Do you have a medical marijuana card?**

Family Medical History:

Family Members:	Medical Problems?	Deceased? Age?

Surgeries/Hospitalizations (please include dates):

Marital Status? **Children?**

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For Patient's Under 18 Years of Age

Patient Name:	
Responsible Party Name and Relationship:	
DOB:	Social Security #:
Mailing Address (if different from patient):	
Phone:	Email:
Employer & Address:	

I give permission for the following individuals to seek medical care for my child:	
Name:	Relationship To Child:
Guardian Signature & Date:	