LoginClinics
WHY WALK-IN WHEN YOU CAN LOG-IN?

LOGINCLINICS CLIENT INFORMATION SHEET

Full Name	Today's Date
Mailing Address	City, State, Zip
Home Phone #	Cell Phone #
Email Address	Prefered Method of Contact (circle one) **Email** Phone Call Text
Birth Date	Age
Gender	Employer/School

Medications	Dosages

Medication / Food Allergies	Type of Reaction

Insurance Carrier	Subscriber Name
Effective Date	Subscriber DOB
Plan Number	Group #
Mailing Address	Phone Number

Pharmacy Name	Pharmacy Address

Medical History (circle):

Diabetes High Blood Pressure Kidney Problems High Cholesterol Liver Problems Heart Disease Asthma COPD Current Smoker Past Smoker Obesity (BMI > 35) Auto Immune Disorder

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Surgical History (circle):

Appendix Removal Gall Bladder Removal Colon Surgery Heart Surgery Lung Surgery Orthopedic Injuries/Surgeries

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Primary Care Provider (Name, Practice Name and City/Town)

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By signing below, I give LoginClinics I understand and agree to the following:

- I have reviewed the HIPAA privacy disclosures found here:
  - https://loginclinics.com/wp-content/uploads/2020/11/HIPAA-Privacy-Policies.pdf
  - All of my questions have been answered and I can access a copy of this form anytime online.
- I have reviewed the "Informed Consent for TeleHealth Services" found here:
  - https://loginclinics.com/wp-content/uploads/2020/11/Informed-Consent-for-Telehealth-Services.pdf .
  - All of my questions have been answered and I can access a copy of this form anytime online.
- I agree to have my insurance on file billed for the test(s) or visits I schedule and participate in.
- I agree to pay the copay on my card at the time service is rendered.
- If there is a remaining/uncovered balance, I agree to pay the remaining balance.
- If I have a card on file, I agree to charging my card in full for this balance.
- I have been given ample time to ask questions and any questions that I have asked have been answered to my satisfaction.

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Signature of Patient or Authorized Representative Date

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Printed Name of Patient or Authorized Representative

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If Authorized Representative, Relation to Patient