Golden Plains Community Hospital Clinics

(806) 467-5350

PATIENT INFORMATION

First Name_____MI _____ Last Name_____

Date of Birth _____ Age: _____ Birth Sex: [ ]Female [ ] Male

Emergency Contact Name_____Emergency Contact Phone # _____

Personal Physician_____

LEGAL GUARDIAN:

First Name _____ Last Name _____

Date of Birth _____ Age: _____ Birth Sex: [ ]Female [ ] Male

Mailing Address _____City _____State_____Zip_____

Physical Address_____City _____State_____Zip_____

Home Phone # _____Cell Phone # _____

E-Mail address_____

AUTHORIZATIONS AND ACKNOWLEDGEMENT

I voluntarily request that Golden Plains Community Hospital Clinic and such assistants as they may deem necessary, manage/treat my condition and I hereby release Golden Plains Community Hospital, Clinics, and any other participating health care providers from any and all liability. The duration of this consent identified and continues until revoked in writing.

I understand all of the above and hereby state that the information is correct to the best of my knowledge. My signature indicated that I have read the above and grant the request of authorizations.

X_____ _____ _____

Signature of Patient or legal guardian **Printed Name** **Date**