PATIENT INFORMATION

First Name MI Last Name Gender M F

Address

City State Zip

Social Security # Date of Birth

Employment Status: Full Time Part Time Self Employed Retired Not Employed Full Time Student

Marital Status: Married Single Divorced Widowed **Race**: White African American Native American Hispanic

Home# Cell # Work #

Communication Preference: Telephone Mail E-mail

RESPONSIBLE PARTY / PARENT OR SPOUSE

First Name Last Name

Address

City State Zip

Home # Work #

Social Security # Date of Birth

INSURANCE INFORMATION

Insurance Company: Policy Holder Date of Birth

Insurance ID# Group #

Patient's Relationship to Policy Holder: Self Spouse Child

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

The Federal Law requires that we make every effort to inform you, the patient, of your rights related to your personal health information. Please check only one below.

_____ Yes, I have read or had explained to me by this office the Notice of Privacy Practices.

_____ No, I have not read this office's Notice of Privacy Practices but I was given the opportunity to read it upfront and declined.

_____ The Notice of Privacy Practices could not be read due to the emergent nature of the care

MEDICAL INFORMATION RELEASE FORM

I authorize all persons listed below the ability to receive materials and or medical information on my behalf

Name Relationship

Name Relationship

Name Relationship

Email Address:

Signature Date