PATIENT INFORMATION

Last Name_____ **First**_____ **MI**_____

Address _____ **City**_____ **State**____ **Zip**_____

Home Phone (___) _____ **Cell Phone** (___) _____ **Marital Status**_____

E-mail address: _____

Date of Birth_____ **Sex**_____ **SSN**_____-_____-_____

Employer_____ **Work phone** (___) _____

Emergency Contact (HIPAA) _____ **Relationship**_____

Phone (_____) _____

Race (please circle): Asian Native American Pacific Islander Black or African American White Other

Ethnicity (please circle): Hispanic or Latin Not Hispanic or Latin

Primary Language:_____

Local Pharmacy (Name, address, & phone)

_____

_____

Mail Order Pharmacy (Name, address, & phone) _____

_____

Do you give us permission to leave detailed phone messages (please circle): Yes No

If yes, please indicate which number(s) where we may leave detailed messages: Home Cell

If no, may we leave a brief message on any number? If yes please circle: Home Cell Work

Types of messages you would like to receive by telephone or e-mail (please circle all that apply):

Lab results Rx Confirmation General Notifications

MEDICAL INSURANCE INFORMATION

Primary Insurance Name_____

Policy number _____ Group number_____

Policyholder _____ Policy holder date of birth_____

Social Security Number of Policy Holder_____

Secondary Insurance Name _____

Policy number _____Group number_____

Policyholder _____Policy holder date of birth_____

Social Security Number of Policy Holder_____

Tertiary Insurance Name_____

Policy number _____Group number_____

Policyholder _____Policy holder date of birth_____

Social Security Number of Policy Holder_____

AUTHORIZATION

I authorize release of my medical records for insurance claim purposes, understanding this MAY include information which may be considered a communicable or venereal disease including, but not limited to: hepatitis, syphilis, gonorrhea, HIV or AIDS. This authorization also allows payment directly to the physician for medical and/or surgical benefits when necessary. **I also understand I am responsible for office charges, co-pays, and deductibles at the time they are incurred. I am responsible for any portion of my bill not covered by my insurance company.** All of the information above is accurate. I understand that this practice uses an automated appointment reminder system. And, if I have given permission above I may also receive automated messages for lab results, prescription confirmation, lab reminders and other general clinic messages. **If an appointment is not cancelled before the time of service a $25.00 fee will be charged.**

_____

Signature of Patient (or Parent of Minor Patient) Date

Family or friend authorized to receive my medical information: (HIPAA)

Name	Relationship	Phone number