

PATIENT INFORMATION FORM

PLEASE INFORM THE RECEPTIONIST IF YOU HAVE HAD ANY TESTS THAT CONCERNS YOUR VISIT TODAY (CT SCAN, X-RAY, MRI, ETC)

Patient Name _____ Social Security Number _____

Address _____ City _____ State _____ Zip _____

Home Telephone _____ Work Telephone _____ Alternate Telephone (Cellular) _____

Date of Birth _____ Male or Female _____ Marital Status _____

Employer _____ Occupation _____

Employer's Address _____ City _____ State _____ Zip _____

Spouse or Responsible Party _____ Social Security Number _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Home Telephone _____ Work Telephone _____ Alternate Telephone (Cellular) _____

Nearest Relative NOT Living at Same Address _____ Relation _____ Home Telephone _____ Alternate Telephone (Cellular) _____

AUTHORIZATION FOR ASSIGNMENT OF INSURANCE CLAIMS AND RELEASE OF MEDICAL RECORDS IS HEREBY GIVEN. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

Privacy Notification

According to HIPAA laws enforced by April 2003, we are obligated to provide patients with a copy of our privacy policy so that you will be informed of what happens to your medical health information in relation to our office. If you would like a copy of this notification, there is a pamphlet at the front desk or simply ask any member of our staff for a copy. We would be more than happy to supply you with this information

Signature _____ Date _____ Cash – Check – Credit Card _____

