PATIENT INFORMATION

PATIENT NAME

Last Name _____ First Name _____ Middle _____

Gender: M F Date of Birth ____ / ____ / ____ Age _____ SS# _____

Home Address _____ Apt # _____

City _____ State _____ Zip _____

Home Phone # _____ Work Phone # _____

Employer Name _____ Occupation _____

Employer Address _____ Apt# _____

City _____ State _____ Zip _____

SPOUSE OR GUARDIAN

Last Name _____ First Name _____ Middle _____

Employer Name _____ Work Phone# _____

Date of Birth ____ / ____ / ____ SS# _____

EMERGENCY Name and address of nearest relative or friend not living with you.

Last Name _____ First Name _____ Middle _____

Home Phone # _____ Work Phone # _____

Relation to Patient _____

PAYMENT METHOD For all services that are not paid by a third party.

❑ Cash ❑ Check ❑ Visa ❑ Mastercard ❑ Discover ❑ American Express

If you have any insurance coverage that might pay a portion of your financial obligations, please ask about our policy.

MY CERTIFICATION

I certify that the above information is correct and I request services.

x _____ _____

Signature of patient or person acting on patient's behalf Date

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MY PRIVACY

I have received a copy of the **Notice of Privacy Practices.** I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: Conduct, plan and direct my treatment and follow-up among the healthcare providers who may be directly and indirectly involved in providing my treatment; Obtain payment from third-party payors; Conduct normal healthcare operations such as quality assessments and accreditation.

x _____ _____

Signature of patient or person acting on patient's behalf Date