



PATIENT INFORMATION

Patient Name: Last: _____ First: _____ Middle: _____
Address: _____ City: _____
State: _____ Zip: _____ Home Ph: _____ Work Ph: _____ Cell: _____
Race: _____ Marital Status: _____ Birthdate: _____ Social Security #: _____
Employer: _____ Employer Phone: _____
If married, spouse's name: _____ Spouse's Employer: _____
Person to notify in case of emergency: _____ Phone: _____
Relatives/friends who are patients here?: _____ Who referred you to us: _____

INSURANCE POLICY INFORMATION Please give your insurance card and driver's license to the receptionist

Insurance Company (Primary): _____
Policy holder's name: _____ Birthdate: ____/____/____
Contract Number: _____ Group Number: _____

CONSENT FOR TREATMENT

I consent to necessary treatment, including drugs, medicine, performance and operation of X-ray, or other studies that may be used by the attending physician, his nurse or staff.

AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION

____ I **DO NOT** wish to have test results or other medical information released to any person other than myself.
____ I **DO** wish to have test results or other medical information released to the following person:

_____ Name	_____ Relationship	_____ Name	_____ Relationship
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You may contact me at the following locations (circle those that apply): Home phone cell phone work phone
You may leave a voicemail message: yes no

It is the responsibility of the patient to notify this office of any changes in the above information. If changes do occur, the patient must file another Authorization for Release of Patient Information with this clinic.

Please understand that it may be necessary for us to disclose some or all of the Information contained in your medical records to other physicians, nurses, and/or healthcare providers (collectively referred to as "providers"). At times, other providers assist using assessing a patient's condition, screening for potential problems, or providing consultation under certain circumstances. All healthcare providers are required by law to maintain your patient confidentiality. Also, due to the increased awareness of quality care and outcome measurements, it may be necessary to disclose information regarding your care to healthcare agencies (both private and governmental), your insurance company and/or your self-insured employer. Regarding the information going to your employer, other than information needed to verify your insurance coverage, the data released will consist of statistical information only.

NON-COVERED SERVICE AGREEMENT

As your physician, I want to provide you with the best care possible. There may be certain routine services performed during your visit(s), such as: DEXA Scans, Pap Smears, Biopsies, Ultrasounds or X-rays, Lab Work, Injections and/or other testing that I feel necessary for the maintenance of your good health and that may NOT be covered by your insurance contract. By signing below, you agree that you will be responsible for costs not covered by your insurance.

NOTICE OF PRIVACY PRACTICES

I acknowledge that I received a copy of the Notice of Privacy Practices.

SIGNATURE: _____ **DATE:** _____