PATIENT INFORMATION

Patient Name

Last_____ First_____ Middle_____

Gender: M F Date of Birth_____/_____/_____ Age _____ SS#_____

Home Address _____ Apt #_____

City _____ State _____ Zip _____

Home Phone # _____ Work # _____ Fax # _____

Cell # _____ Cell Carrier _____

Home Email _____ Work Email _____

Employer Name _____Occupation _____

Employer Address_____

Race/Ethnicity _____ Spoken Language(s) _____

Marital Status _____ # Children _____ Referred By _____

Primary Care Provider _____ Phone # _____

Spouse or Guardian Name

Last_____ First_____ Middle_____

Employer Name _____ Work # _____ Date of Birth_____/_____/_____

Emergency *Name and address of nearest relative or friend not living with you*

Last_____ First_____ Middle_____

Home Phone # _____ Work #_____ 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 inform our staff.

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 payers; Conduct normal healthcare operations such as quality assessments and accreditation.

X_____ _____

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