PATIENT INFORMATION: **DATE:** _____

NAME (LAST, FIRST, MI) _____

ADDRESS _____

CITY, STATE, ZIP _____

PHONE _____ ALTERNATE PHONE _____

EMAIL ADDRESS _____

BIRTHDATE _____ SEX _____ MARITAL STATUS _____ SOCIAL SECURITY _____

RACE/ETHNICITY (please circle): American Indian or Alaskan Native, Asian, Black or African American, White or Caucasian, Hispanic or Latino, Other: _____

PREFERRED LANGUAGE (please circle): English, Spanish, Navajo, German, French, Other: _____

PERSON TO CONTACT IN CASE OF EMERGENCY:

NAME _____ RELATIONSHIP _____ PHONE _____

PRIMARY CARE DR: _____ PHONE _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY _____

SECONDARY INSURANCE COMPANY _____

(COMPLETE INFORMATION BELOW IF OTHER THAN YOURSELF)

PRIMARY CARDHOLDER'S NAME/RELATIONSHIP _____

DOB _____ SOCIAL SECURITY # _____

SECONDARY CARDHOLDER'S NAME/RELATIONSHIP _____

DOB _____ SOCIAL SECURITY # _____

FINANCIAL AGREEMENT

The financial policy of the practice has been fully explained to me and I acknowledge full responsibility for all charges incurred including any additional charges incurred in the collection of this account, if my insurance later determines my services to be noncovered or not a benefit.

PATIENT SIGNATURE: X _____ **DATE** _____

PRIVACY POLICY (HIPAA)

I understand that HIPAA has implemented procedures that require specific authorization for release of my information. I agree to the following statements and understand that I can revoke these at any time by informing the Privacy Officer in writing.

Home telephone #: We may leave a message with a callback number or appointment reminder on voicemail.

Written communication: We may mail postcards to your home address or send you an e-mail.

I have received the NOTICE OF PRIVACY PRACTICES and I have been provided an opportunity to review it.

PATIENT SIGNATURE: X _____ **DATE** _____

LIFETIME INSURANCE AUTHORIZATION

I authorize and request that payments under my medical insurance programs be made directly to pay the provider for any services furnished to me. I also authorize the provider to release any information needed for payment of claims. I further permit copies of this authorization to be used in place of the original.

PATIENT SIGNATURE: X _____ **DATE** _____