

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

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