PATIENT INFORMATION ❑ New Patient ❑ Name Change ❑ Address Change ❑ Insurance Change

THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS: Today's Date ____/____/____

Name _____
Last *First* *M.I.*

Date of Birth: ____/____/____ Age: _____ Social Security #_____ Sex: ❑ Male ❑ Female

ADDRESS:

Mailing Address _____
City *State* *Zip*

Home Phone: ( )_____ Work Phone: ( )_____

Cell Phone: ( )_____ e-mail: _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

PARENT, SPOUSE, OR RESPONSIBLE PARTY *(if different from patient)*

Name: _____ Date of Birth: ____/____/____
Last *First* *M.I.*

Address:_____
City *State* *Zip*

Home Phone: ( )_____ Work Phone: ( )_____

INSURANCE COVERAGE - PRIMARY:

Insurance Co. Name:_____

Name of Policy Holder (Insured):_____

Policy Holder (Insured) Date of Birth: ____/____/____ SS#_____ Sex: ❑ Male ❑ Female

If patient is child, check relationship: ❑ Mother ❑ Father ❑ Other_____

INSURANCE COVERAGE - SECONDARY:

Insurance Co. Name:_____

Name of Policy Holder (Insured):_____

Policy Holder (Insured) Date of Birth: ____/____/____ SS#_____ Sex: ❑ Male ❑ Female

If patient is child, check relationship: ❑ Mother ❑ Father ❑ Other_____

Do you give our office permission to discuss your medical information with family members?

❑ YES ❑ NO If yes, please provide their names and phone numbers below.

Name: _____ Relationship: _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES:

My signature below indicates that I have received and/or reviewed a copy of my physician's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices). I have been given the option of signing a separate Patient Consent Form.

Patient or Responsible Party Signature _____

I authorize you to communicate with me by "unsecure" text and "unsecure email":

_____ _____ _____
Number Email Address Signature

I Authorize the practice to communicate with me by "unsecure" answering machine or voice-mail.

_____
Signature