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PATIENT INFORMATION FORM

PATIENT DEMOGRAPHICS

PATIENT NAME: LAST _____ FIRST _____ M.I. _____ AGE _____

BIRTH DATE _____ SOCIAL SECURITY # _____ - _____ - _____ MARITAL STATUS _____

ADDRESS _____ CITY _____

STATE _____ ZIP CODE _____ EMAIL ADDRESS _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

EMPLOYER _____ LOCATION _____

SPOUSE'S NAME: LAST _____ FIRST _____ M.I. _____

BIRTH DATE _____ SOCIAL SECURITY # _____ - _____ - _____

WORK PHONE _____ CELL PHONE _____

INSURANCE

Please Note: A copy of the front and back of your card(s) may be provided in place of completing this section

PRIMARY INSURANCE _____

ADDRESS _____

POLICY # _____ GROUP # _____ GROUP NAME _____

SECONDARY INSURANCE _____

ADDRESS _____

POLICY # _____ GROUP # _____ GROUP NAME _____

IN CASE OF EMERGENCY

NAME _____ RELATIONSHIP _____

ADDRESS _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

Patient or Legal Guardian Signature	Print Patient Name or Legal Guardian	Date