

PATIENT INFORMATION

Last Name _____ First Name _____ Middle _____

Gender: M F Date of Birth ___/___/___ Age _____ SS# _____

Home Address _____ Apt # _____

City _____ State _____ Zip Code _____

Home Phone (____) _____ Work Phone (____) _____ Cell (____) _____

E-Mail Address _____

Marital Status: Single Married Separated Divorced Widow

Employer Name _____ Occupation _____

Employer Address _____ Suite # _____

City _____ State _____ Zip Code _____

SPOUSE / GUARDIAN / RESPONSIBLE PARTY (If other than self)

Last Name _____ First Name _____ Middle _____

Employer Name _____ Work Phone _____ Cell _____

Relation to Patient _____ Date of Birth _____ SSN# _____

EMERGENCY CONTACT Name and address of nearest relative or friend not living with you.

Last Name _____ First Name _____ Middle _____

Home Phone (____) _____ Work Phone (____) _____ Cell (____) _____

Relation to Patient _____

Are you interested in applying for our time of service discount program? (patients with no insurance only) __ Yes __ No

How did you hear about us? __ Yellow Pages __ Physician __ Internet/Website __ Sign __ Insurance __ Other

If you were referred by a physician or patient, please provide his/her full name: _____

I certify that the above information is correct and I request services

X _____ Date _____
Signature of Patient or Representative

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 application.

X _____ Date _____
Signature of Patient or Representative