Patient Information Form

Patient Name____Date Of Birth_______________

Social Security #____________ Marital Status: S / M / D / W / Sep Sex: Male / Female Race: _________

Ethnicity__________________ Religion__________________Primary Language__________________

Home Address________________________________City/ State____________________ Zip _________

Home Phone #_____________________ Cell #_____________________Work #__________________

Employer Name________________________________ Occupation______________________________

Email______________________________________Best way to be contacted: (circle) Home / Cell / Work

Emergency Contace Name & Relationship_______________________________Phone #_______________

Responsible Party/ Policy Holder: (All required) Name:_____________________________________
DOB_______________SS# __________________

****REFERRING PHYSICIAN:____**

****FAMILY/ PRIMARY PHYSICIAN:____**

****PREFFERED PHARMACY, ADDRESS & PHONE____**

IF PATIENT IS MINOR OR STUDENT PLEASE COMPLETE THE FOLLOWING:

*Father's Name*_____________________Phone #___________Address __________________________

Father's Employer___________________________Occupation______________Work #______________

*Mother's Name*_____________________Phone #___________Address __________________________

Mother's Employer___________________________Occupation______________Work #______________

Confidential Channel Communication Request

As required by the Health Information Portability and Accountability Act (HIPAA) of 1996, you have a right to request that communications concerning your personal health information be made through confidential channels.

I hereby request the use of the following confidential channels for the communications of information related to my personal health, treatment or payment for treatment. This request supercedes any prior request for confidential communications I may have made.

1- May we discuss your Personal Health Information with anyone else? (You must fill in the name and phone number if okay.)

Spouse__________________Parent_______________Children_____________Other__________

Patient or Responsible Persons Signature ________________________________ Date ______