WELCOME TO OUR PRACTICE!

PATIENT INFORMATION

First Name: ____________________ MI: ______ Last Name: _____________________

Address: ____

City, State, Zip: ____

Home Phone: _______________ Work Phone: ______________ Cell: _______________

Birthdate: _________________________ Social Security #: _______________________

Name of Parent/ Guardian(if patient is a child):_______________________________

Address: __________________________________City, State, Zip:_________________

Birthdate: _________________________ Social Security #: _______________________

Home Phone: _______________ Work Phone: ______________ Cell: _______________

INSURANCE INFORMATION

Name of Insured: ____

Insured SS #: _______________________ Insured Date of Birth:__________________

Employer: _________________Relationship to Patient: ()Self ()Spouse ()Child ()Other

Insurance Company: _______________________ Phone #: _______________________

Address: _________________________ City, State, Zip: _________________________

Group Number: __________________ ID # (if other than SS#): __________________

NOTICE OF PRIVACY PRACTICES

The notice of privacy practices describes how health information about you may be used and disclosed and how we are required by federal and state law to maintain the privacy of your health information. I have read and understand the notice of privacy practices. I am signing it voluntarily. I authorize the disclosure of my health information as needed.
Patient Signature(or guardian):______________________________Date:________________