

## 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:** \_\_\_\_\_

**\*\*PREFERRED 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** \_\_\_\_\_

