

# PATIENT INFORMATION

## PATIENT NAME

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle \_\_\_\_\_  
Gender: M F Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_\_ SS# \_\_\_\_\_  
Home Address \_\_\_\_\_ Apt # \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_  
Employer Name \_\_\_\_\_ Occupation \_\_\_\_\_  
Employer Address \_\_\_\_\_ Apt# \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## SPOUSE OR GUARDIAN

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle \_\_\_\_\_  
Employer Name \_\_\_\_\_ Work Phone# \_\_\_\_\_  
Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SS# \_\_\_\_\_

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

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle \_\_\_\_\_  
Home Phone # \_\_\_\_\_ Work Phone# \_\_\_\_\_  
Relation to Patient \_\_\_\_\_

## PAYMENT METHOD For all services that are not paid by a third party.

Cash  Check  Visa  Mastercard  Discover  American Express

*If you have any insurance coverage that might pay a portion of your financial obligations, please ask about our policy.*

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## MY CERTIFICATION

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

x \_\_\_\_\_  
Signature of patient or person acting on patient's behalf Date

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## MY PRIVACY

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 accreditation.

x \_\_\_\_\_  
Signature of patient or person acting on patient's behalf Date