Patient Information & Authorization

PATIENT NAME_____Social Security #_____

Date of Birth_____ Address_____

City_____State/Zip_____Home Phone_____

Employment_____Work Phone_____Cell Phone_____

E-mail_____

HUSBAND/PARENT_____Social Security #_____

Date of Birth_____Address_____

City_____State/Zip_____Home Phone_____

Employment_____Work Phone_____Cell Phone_____

EMERGENCY CONTACT #1_____Phone_____

EMERGENCY CONTACT #2_____Phone_____

Family Physician_____Religion_____

MEDICAL ALLERGIES_____

PHARMACY USED MOST FREQUENTLY_____

INSURANCE

Policy Holder_____Ins. Company_____

ID No._____Group No._____

AUTHORIZATION TO MAIL, CALL or E-MAIL

I certify that I understand and am responsible for the privacy risks of the mail, phone calls, and e-mails. I hereby authorize a representative or physician of this office to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying this office to that effect in writing.

_____ _____

SIGNATURE **DATE**

MEDICARE BENEFICIARY SIGNATURE ON FILE FORM

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or Carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

_____ _____

SIGNATURE **DATE**