Patient Information

PATIENT NAME_____ Date of Birth: _____

Address:_____ City: _____ State/Zip Code:_____

Cell Phone: _____ Home Phone: _____

E-MAIL: _____

Employment:_____ Work Phone:_____

HUSBAND/PARENT: _____ Date of Birth: _____

Address:_____ City: _____ State/Zip Code:_____

Cell Phone: _____

Employment:_____ Work Phone:_____

EMERGENCY CONTACT #1_____ Phone: _____

EMERGENCY CONTACT #2_____ Phone: _____

Family Physician: _____

MEDICAL ALLERGIES: _____

PREFERRED PHARMACY: _____

INSURANCE (Give copy to receptionist)

Policy Holder:_____ Insurance Company: _____

ID Number: _____ Group No. _____

AUTHORIZATION TO MAIL, CALL, TEXT OR EMAIL

I certify that I understand and am responsible for the privacy risk of the mail, phone calls, and emails. **I hereby authorize a representative or physician of this office to mail, call, text or email 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 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. Regulation pertaining to Medicare assignment of benefits apply.

_____ _____

SIGNATURE **DATE**