PATIENT INFORMATION **DATE**_____

NAME(Last, First, MI)_____

BIRTHDATE_____SEX _____MARITAL STATUS_____SOCIAL SECURITY_____

MAILING ADDRESS_____

CITY, STATE, ZIP_____

PHONE_____CELL PHONE_____

EMAIL_____

RACE/ETHNICITY (please circle) American Indian or Alaskan Native, Asian, Black or African American, White or Caucasian, Hispanic or Latino, Native Hawaiian or other Pacific Islander, Native American, Other_____

PREFERRED LANGUAGE (please circle) English, Spanish, Navajo, German, French, Other_____

PERSON TO CONTACT IN CASE OF EMERGENCY:

NAME_____RELATIONSHIP_____PHONE_____

PRIMARY CARE PHYSICIAN_____PHONE_____

REFERRING PHYSICIAN_____PHONE_____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY_____ID#_____

PRIMARY INSURANCE HOLDERS NAME_____DOB _____/_____/_____

PRIMARY HOLDERS SOCIAL SECURITY #_____

SECONDARY INSURANCE COMPANY_____ ID#_____

SECONDARY INSURANCE HOLDERS NAME_____ DOB _____/_____/_____

SECONDARY HOLDERS INSURANCE SOCIAL SECURITY #_____

FINANCIAL AGREEMENT

The financial policy of the practice has been fully explained to me and I acknowledge full responsibility of all charges incurred including any additional charges incurred in the collecting of this account, if my insurance later determines my services to be a noncovered or not a benefit.

PATIENT SIGNATURE_____**DATE**_____

PRIVACY POLICY (HIPAA)

I understand that HIPAA has implemented procedures that require specific authorization for release of my information. I agree to the following statements and understand that I can revoke these at any time by informing the Privacy Officer in writing.

HOME TELEPHONE: We may leave a message with a callback number or appointment reminder on voicemail.

WRITTEN COMMUNICATION: We may mail postcards/letters to your home address or send you an email.

I have received the NOTICE OF PRIVACY PRACTICES and have been provided an opportunity to review it.

PATIENT SIGNATURE_____**DATE**_____

LIFETIME INSURANCE AUTHORIZATION

I authorize and request that payments under my medical insurance programs be made directly to pay the provider for any services furnished to me. I also authorize the provider to release any information needed for payment claims. I further permit copies of this authorization to be used in place of the original.

PATIENT SIGNATURE_____**DATE**_____