Date: _____ Patient ID# _____

PATIENT INFORMATION RECORD (Please print or write legibly)

Last Name _____ First _____ Middle _____

Preferred Name _____ Marital Status _____

Date of Birth _____ Sex ❑ Male ❑ Female SSN# _____

Race: ❑ White ❑ Pacific Islander ❑ Black ❑ American Indian ❑ Asian ❑ Other

Ethnicity: ❑ Hispanic/Latino ❑ Not Hispanic/Latino

Preferred Language: ❑ English ❑ Spanish ❑ Other

Patient's Mailing Address _____ City _____

State _____ Zip Code _____ Email _____

Home Phone (____) _____ Work (____) _____

Cell (____) _____ Primary Number ❑ Home ❑ Work ❑ Cell

Preferred contact for Appointments/Results? ❑ Voice Call ❑ Text *(could result in charges from your carrier)* ❑ Email

Employer _____ Occupation _____

Employer Address _____

Preferred Pharmacy _____ Family Doctor _____

Referring Doctor _____

Insurance _____ Policy Number _____

Policy Holder's Name _____ Date of Birth _____

SPOUSE'S NAME AND ADDRESS

Spouse Name _____ Spouse Date of Birth _____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name _____ Phone (____) _____

Address _____ Relation _____

FOR MINORS AND STUDENTS

Father's Name _____ Date of Birth _____

Mailing Address _____ Phone (____) _____

_____ SSN# _____

CITY STATE ZIP

Mother's Name _____ Date of Birth _____

Mailing Address _____ Phone (____) _____

_____ SSN# _____

CITY STATE ZIP

TURN OVER TO CONTINUE ON BACK

I hereby authorize my healthcare professional to evaluate and render treatment to me. This authorization will be effective until revoked in writing by me or my legal representative.

I authorize my physician, or employees and/or agents to discuss my medical/billing information with me/my spouse/next of kin/or caregiver. I authorize use of a telephone appointment reminder system. I give prior express consent to contact me by sending text messages (which could result in charges to me from my carrier) or e-mails, using any e-mail address or cell phone number, for the purpose of treatment, insurance, appointments, and/or payment.

I have been made aware and understand that the physicians/nurses may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my providers to see this protected health information.

I authorize the release of any medical or other information necessary to process my medical claims. I also request payment of government benefits either to myself or to the party who accepts assignment below.

I authorize payment of medical benefits to the undersigned physician or supplier for services described on my medical claim.

Signature _____ **Date** _____

HIPAA Notice and Acknowledgment

Acknowledgment:

I acknowledge that I have been offered/received the Notice of Privacy Practices.

Signature _____ **Date** _____

List any person(s) you would like for us to share your medical information with. This includes balances, appointments, insurance questions. etc.

Name	Relationship	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____

Signature _____ **Date** _____