Personal Information

Name_____
Last First
Birthdate_____ SS#_____ Driver License #_____

☐Male ☐Female ☐Minor ☐ Single ☐ Married ☐Divorced ☐Widowed ☐Separated

Address_____
Street City State Zip Code
Employer_____ Occupation_____

Referred By_____ Your Email Address_____

Telephone

Home Phone_____ Work Phone_____ Cell Phone_____

Where do you prefer to receive calls? ☐Home ☐ Work ☐ Cell

May we leave messages on your answering machine such as your appointment time/date, laboratory or biopsy results?

No ☐ Yes ☐

Do you give us permission to share your information with anyone else?
☐No ☐Yes, please indicate who (full name/relationship to patient) _____

Emergency Contact

Name_____ Relationship_____ Phone_____

Responsible Party/Insurance: Who is responsible? If different from self (the patient)

☐Self ☐ Spouse ☐ Parent(s) ☐ Other_____

Name_____ Relationship to Patient_____

Birthdate_____ SS#_____ Driver License#_____

Address_____
Street City State Zip
Home Phone_____ Cell_____

Authorization/Release/Acknowledgement

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to my child/minor or me during the period of such care to third party and/or other health practitioners. I understand, and have been provided a copy of this Notice of Privacy Rights, detailing how the information may be used and disclosed as permitted under federal and state law. I understand that I have the right to review the notice prior to signing. I understand that the organization reserves the right to change its notice and practices and, prior to implementation, will mail a copy of any revised notice to the address I've provided.

I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I understand that a parent/guardian must attend each visit with minor, unless another approved arrangement is established between the parent/guardian and us. The parent/guardian is responsible for providing us a written consent of such agreement in advance; otherwise we may have to reschedule the minor's appointment.

I understand that I have reviewed all forms and complete them to the best of my knowledge.

Signature of patient or parent/guardian if minor_____ Date_____