HERMES HEALTHCARE LLC
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PATIENT INFORMATION FORM

Patient Information						
Name:				**DOB:**		
Address:						
Phone:		**Fax:**				
SSN:		**Sex**	Select from Drop Down	Marital Status:	Select from Drop Down	
Email:						
Ethnicity:	Select Ethnicity from Drop Down					
Contact Person(s):		**Phone:**				
Responsible Party if not Self:						
Responsible Party for Medical Decisions:						

Primary Care Physician Information	
Name:	
Address:	
Phone:	

Medicare Screening Information		
	Yes	**No**
Is the patient a veteran?	☐	☐
If yes, Did the VA refer the patient?	☐	☐
If yes, Does the patient have a Fee Basis ID Card?	☐	☐
Is the visit due to an accident?	☐	☐
Is the patient covered by an employer's work group health plan?	☐	☐

Mission to Disclose Protected Health Information:
In general the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.