HERMES HEALTHCARE LLC
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PATIENT INFORMATION FORM

Patient Information						
Name:				**DOB:**		
Address:						
Phone:		**Fax:**				
SSN:		**Sex**		Marital Status:		
Email:						
Ethnicity:						
Contact Person(s):	Name: Phone: Address: Relationship:	**<-- Person 1 to left, _____ person 2 to right--->**	Name: Phone: Address: Relationship:			
Responsible Party if not Self:	Name Relationship Address City, State, Zip Phone					
Responsible Party for Medical Decisions:	Name Relationship Address City, State, Zip Phone					

Primary Care Physician Information	
Name:	Physician Name.
Address:	Address Line 1 Address Line 2 City, State, Zip
Phone:	Enter Phone Number.

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.