PATIENT INFORMATION FORM

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| Patient Information | | | | | | | |
| **Name:** | Enter Patient Name | | | **DOB:** | | Click here to enter a date. | |
| **Address:** | Address Line 1  Address Line 2  City, State, Zip | | | | | | |
| **Phone:** | Enter Phone Number. | **Fax:** | Enter Fax Number | | | | |
| **SSN:** |  | **Sex** | Select from Drop Down | | Marital Status: | | Select from Drop Down |
| **Email:** | Enter Patient Email | | | | | | |
| **Ethnicity:** | Select Ethnicity from Drop Down | | | | | | |
| **Contact Person(s):** | Name: | **<--Person 1 to left,**  **\_\_\_\_\_\_\_**  **person 2 to right---->** | Name: | | | | |
| Phone: | Phone: | | | | |
| Address: | Address: | | | | |
| Relationship: | 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 | | | | | | |

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

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| 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?** |  |  |

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| **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. |