PATIENT INFORMATION FORM

|  |
| --- |
| Patient Information |
| **Name:** | Enter Patient Name | **DOB:** | Click here to enter a date. |
| **Address:** | Address Line 1Address Line 2City, 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 |

|  |
| --- |
| 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. |