HERMES HEALTHCARE LLC

3343 West Central Avenue - Wichita, Kansas 67203

PATIENT INFORMATION FORM

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

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.