



HERMES HEALTHCARE INC

3343 West Central Avenue - Wichita, Kansas 67203

PATIENT INFORMATION FORM

Patient Information					
Name:				DOB:	
Address:					
Phone:		Fax:			
SSN:		Sex		Marital Status:	
Email:					
Ethnicity:					
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				



HERMES HEALTHCARE LLC

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Primary Care Physician Information	
Name:	
Address:	
Phone:	

Medicare Screening Information		
	Yes	No
Is the patient a veteran?	<input type="checkbox"/>	<input type="checkbox"/>
<i>If yes, Did the VA refer the patient?</i>	<input type="checkbox"/>	<input type="checkbox"/>
<i>If yes, Does the patient have a Fee Basis ID Card?</i>	<input type="checkbox"/>	<input type="checkbox"/>
Is the visit due to an accident?	<input type="checkbox"/>	<input type="checkbox"/>
Is the patient covered by an employer's work group health plan?	<input type="checkbox"/>	<input type="checkbox"/>

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.