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Patient Name: _____
(Last) (First) (M.I.)

Date of Birth: _____ Age: _____ Sex: Male/Female

SSN: _____ Marital Status: S M D W Email Address: _____

Race: American Indian or Alaska Native Asian Native Hawaiian or Pacific Islander
 Black or African American White Declined

Ethnicity: Hispanic or Latino Not Hispanic or Latino Declined

Language: English Spanish Japanese Chinese Korean French German Russian Other

Home Address: _____

City, State, Zip: _____

Home Number: _____ Mobile Number: _____

Employer/Occupation: _____ Employer Work #: _____

Emergency Contact: _____
(Name) (Number) (Relationship)

If Patient is a minor:

Parent/Guarantor: _____
(Last) (First) (M.I.)

Date of Birth: _____ SSN: _____

Home Address: _____

City, State, Zip: _____

(Initials) ASSIGNMENT OF INSURANCE BENEFITS: If the patient is entitled to medical benefits of any type arising out of a contract with a health insurance company, these benefits are hereby assigned to this office for application on the patients bill.

(Initials) RELEASE OF INFORMATION: This office may disclose the patients record for this visit, to those health insurance companies responsible for payment of all or part of the office visit.

(Initials) FINANCIAL AGREEMENT: I agree to pay all portions of this account, which are not covered by insurance or other sources of payment. This office will bill most insurance and will keep me informed of all insurance or other sources of payments and Balances due from me.

(Initials) RECEIPT OF NOTICE OF PRIVACY PRACTICES/PATIENT RIGHTS AND RESPONSIBILITIES

(Initials) SCRIBE SERVICES: We often utilize an employee in the exam room and during virtual visits to document your visit. Please be aware this employee follows all HIPAA privacy practices and values your privacy, they are present only to document your visit and assist the provider.

PATIENT SIGNATURE: _____ Date: _____

