Today's Date: __________

PATIENT INFORMATION

Patient Name: ______________________________ Date of Birth _____/_____/_____
First MI Last

Address: ____
Street City State Zip

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

Which phone number is best to leave messages and reminders? ❑ Home ❑ Cell

Social Security No. _____-_____-_____ Sex: M/ F Marital Status: Single / Married / Widowed / Divorced

E-mail Address: ____

Employer's Name: ______________________ Occupation/Position: ______________

Employer's Address: ____
Street City State Zip

Pharmacy Name: ____
Name City State Phone

Referring Physician: ____
Name Address

Primary Physician: ____
Name Address

Emergency Contact: ____
Name Phone Relationship

How did you hear about us: ____TV ____Internet ____Physician ____Relative ____Insurance ____Friend ____Other ______________________

Primary Language: English____ Spanish____ Arabic____ Cantonese____ Hebrew____ Japanese____ Korean Mandarin____ Russian____ Decline to answer____

Ethnicity: Hispanic or Latino_____ Not Hispanic or Latino_____ Decline to answer_____

Race: American Indian/Alaska Native____ Asian____ Black/African American____ White____ Native Hawaiian/Pacific Islander____ Other____ Decline to answer____

INSURANCE

Primary Insurance Company: ______________________ Subscriber Name: ______________

Subscribers Date of Birth: _____/_____/_____

Secondary Insurance Company: ______________________ Subscriber Name: ______________

Subscribers Date of Birth: _____/_____/_____

Separate Vision Insurance Plan: VSP Cigna Metlife None Subscriber Name: ______________

Subscribers DOB: _____/_____/_____ Last 4 digits of Subscribers SS#: ____-____-____

Person Responsible for payment, if not patient: ______________________________

Relationship to patient: ______________ Social Security Number: ____-____-____

Address: ______________________ City, State, Zip: ______________________

Daytime phone: ______________________

Account No. ________________

Patient Name: ____
First MI Last

Date of Birth: _____/_____/_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information.

I acknowledge that I have received your Notice of Privacy Practices. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment payment or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

SIGNATURE OF PATIENT OR AUTHORIZED PARTY: X ______________________________ DATE: ______________

Authorized Party if other than patient: ____
Print Name

Relationship: ______________________________ Daytime phone number: ______________________________

Staff use only:
The Patient or Authorized Party noted above was provided the Notice of Privacy Practices and this Acknowledgement Form and did not sign the Acknowledgement Form.
Reason for not signing: ____
Name: ______________________________ Date: ______________
Position: ______________________________

MEDICAL/FINANCIAL DISCLOSURE

Dear Patient,

In order to protect your privacy and be in compliance with the new laws regarding patient privacy, we need your signature on this form to disclose medical/financial information to any person other than yourself. If you do not sign this form, we will not divulge any medical/financial information about you to anyone other than your insurance company.

NAME	RELATIONSHIP TO YOU	PHONE

SIGNATURE OF PATIENT: X ______________________________ DATE: ______________

SIGNATURE OF WITNESS: ______________________________ DATE: ______________