PATIENT REGISTRATION

PATIENT NAME (Last, First, Middle Initial) _____

DATE OF BIRTH: _____SOCIAL SECURITY NUMBER_____

ADDRESS: _____

CITY, STATE, ZIP: _____

HOME PHONE_____MESSAGE PHONE_____CELL _____

EMAIL ADDRESS:_____

SEX: MALE__ FEMALE__

EMPLOYER:_____OCCUPATION_____

OTHER MEMBERS OF YOUR FAMILY SEEN BY THIS OFFICE:_____

_____

EMERGENCY CONTACT:_____PHONE NUMBER:_____

HOW DID YOU HEAR ABOUT
US?_____

NOTICE OF PRIVACY PRACTICES-ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask us to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our Business Manager.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

_____

(Patient or Legally Authorized individual signature) (Date)