PATIENT INFORMATION

ACCT# ______
STAFF ______

PATIENT NAME ____ **Male** **Female**
LAST FIRST MIDDLE

DATE OF BIRTH ____________ **SOCIAL SECURITY#** ______________________

MAILING ADDRESS______________________________ **HOME PHONE** ( ) ___________
STREET

___________________________________ **E-MAIL ADDRESS**__________________________
CITY STATE ZIP

CHECK EACH STATEMENT ACKNOWLEDGING YOU HAVE READ.

I acknowledge that I am financially responsible for all charges. If it becomes necessary to involve collections for any amount owed on this or subsequent visits the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to release information to secure payment of benefits.

I have been offered a copy of this offices Notice of Privacy Practices.
*** You May Refuse to Sign This Acknowledgement ***

Print Patients Name ________________________________

Signature ____ Date ___________

How did you hear about us? Established Patient New Patient Yellow pages

Friend / Family Member Recommended by: Dr. ____________________________

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)