

WELCOME TO OUR PRACTICE

PATIENT INFORMATION:

First Name _____ Last Name _____ MI _____

Social Security# _____ - _____ - _____ Birthdate ____/____/____ Age _____

Address: _____ City _____ State _____ Zip _____

Home Phone () _____ Cell() _____ Work() _____

e-mail address _____

Marital Status M / S / W / D Race: Caucasian / African American / Other _____

Primary Language Spoken: English, Spanish, Other _____ MALE / FEMALE

EMPLOYER:

Name _____ Address: _____

SPOUSE ___ PARENT ___ GUARDIAN ___ (please check one that applies)

Name: _____ Birthdate ____/____/____

Social Security# _____ Phone# _____

EMERGENCY CONTACT:

Name: _____ Relationship _____

Phone#() _____

Who are we permitted to talk to, other than you, regarding appointments, insurance/claims or test results

Name: _____ Relationship _____

MAYSVILLE FOOT & ANKLE CLINIC AUTHORIZATION OF RECEIPT NOTICE OF PRIVACY PRACTICE

I hereby acknowledge the receipt of the Notice of Privacy regarding my Protected Health Information

SIGNATURE

DATE