New Patient Information Update

Patient's Name:___________________________________DOB:______________________________

Email: ____

May we send you an invite to our patient portal?____

Primary Care Physician:

Name: ________________________________Phone:____

Emergency Contact Details:

Contact:___________________________________Relationship:________________________________

Phone:____________________________________ Mobile:____________________________________

Pharmacy Details:

Pharmacy name:____

Pharmacy Address:____

Pharmacy Phone: ____

Who may we disclose your Protected Healthcare Information to on your behalf?

Name:____ Phone:______________________________

Relationship:_________________________________ Address:__________________________________

2. Name:____ Phone:______________________________

Relationship:_________________________________ Address:__________________________________

May we leave your results on your voicemail? If yes, what phone number? ____________________

I verify that the above information is factual and true to the best of my knowledge. I authorize the doctor to employ medicines and other equipment or aids as he/she deems necessary in order to provide the proper patient care. I understand that payment, proof of insurance, and/or copay is due at the time of service.

I have reviewed the Offices Notice of Privacy Practices, which explains how my medical information will be used and disclosed.

I authorize this office to apply benefits on my behalf for the covered services rendered. I Certify that the insurance information I have provided is factual and correct.

Signature: _____________________________________ Date: __________________________________