

Patient Information Form

Chart # _____ Date _____

Patient Name _____ DOB _____
First MI Last mm dd yyyy

If patient is under the age of 18, responsible party must complete remainder of this section

Name of Responsible Party _____
First MI Last

Home Phone # _____ Cell Phone # _____

Work Phone # _____ Patient's SSN _____ Sex M F

E-Mail _____

Mailing Address _____
Street City State Zip

Secondary Address _____
Street City State Zip

Age _____ Occupation _____
(If retired, prior occupation)

Marital Status Married Single Widowed Divorced Long-Term Commitment

Spouse Name _____

Emergency Contact _____ Phone # _____

Relation to Patient _____

Primary Care Physician _____ Phone # _____

How did you hear about us?

Mail Newspaper Ad Promotional Call Radio Insurance

Yellow Pages Sponsored Event Health/Senior Fair Website Employer

Referred by Friend _____

Referred by Physician _____

Other _____

Reason for Appointment _____

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We believe in, and strive to provide, a convenient location with ample parking and expect our staff to always be professional, courteous, and helpful. To provide you with the highest level of service, please rate your experience of the following areas:

Location and accessibility	<input type="radio"/> Excellent	<input type="radio"/> Average	<input type="radio"/> Poor
Adequate parking	<input type="radio"/> Excellent	<input type="radio"/> Average	<input type="radio"/> Poor
Convenience of appointment times	<input type="radio"/> Excellent	<input type="radio"/> Average	<input type="radio"/> Poor
Friendly greeting	<input type="radio"/> Excellent	<input type="radio"/> Average	<input type="radio"/> Poor
Clean and welcoming environment	<input type="radio"/> Excellent	<input type="radio"/> Average	<input type="radio"/> Poor

What can we do to make your next visit more comfortable?

Insurance Information

Please give your insurance information to our front office staff so we can make a copy for our records.

Please read carefully and sign below

- I give permission to my AudigyCertified™ practice to release information, verbal and written (contained in my medical record and other related information), to my insurance company, rehab nurse, case manager, attorney, employer, related healthcare providers, assignees, and/or beneficiaries and all other related persons. Information without patient identifiers may be used for quality purposes.

_____ **Initial to refuse permission to release records**

- I acknowledge that I have received and reviewed the Health Insurance Portability & Accountability Act (HIPAA) policy of this office.
- I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for professional services or purchases rendered.
- I have read all the information on this sheet, completed the above answers, and certify this information is true and correct to the best of my knowledge and hereby give my AudigyCertified practice permission to treat my concerns.

I have read and understand all the above information.

Patient Signature (A copy of this signature is as valid as the original)

Date

Signature of Parent or Guardian

Date