

FAMILY PRACTICE CENTER, P.C.

PATIENT INFORMATION						Chart # _____
First Name		Middle Name		Last Name		Sex M F
Social Security # - -		Maiden Name (if applicable)		Birthdate (Month / Day / Year) / /		
Address				Home Telephone Number () -		
City		State		Zip		Alternate Telephone Number () -
Employer				Work Telephone Number () -		
Immediate Family Members						
Spouse:			Children:			
IF PATIENT IS UNDER 18, PLEASE COMPLETE SHADED SECTION						
Parent / Guardian		First Name		Last Name		Sex M F
						Birthdate (Month / Day / Year) / /
Are you the Guarantor (financially responsible)? Yes No		If not, please provide the name of the Guarantor		Guarantor's Social Security # - -		
PRIMARY INSURANCE			SECONDARY INSURANCE			
If no insurance, check box:			If no secondary insurance, check box:			
Insured Name		Sex M F	Insured Name		Sex M F	
Insured Social Security # - -		Insured Birthdate / /	Insured Social Security # - -		Insured Birthdate / /	
Primary Insurance		Insured ID	Secondary Insurance		Insured ID	
Group #	Effective Date	Insured Relationship to the Patient		Group #	Effective Date	Insured Relationship to the Patient
PREFERRED PHARMACY						
Pharmacy Name					Pharmacy Telephone Number () -	
DRUG ALLERGIES						
List Drug Allergies (Please write NONE if you have no drug allergies)						
EMERGENCY CONTACTS						
First Name		Last Name		Home Telephone Number () -		Alternate Telephone Number () -
First Name		Last Name		Home Telephone Number () -		Alternate Telephone Number () -
SIGNATURE (AUTHORIZATION TO TREAT PATIENT IF UNDER 18)						
The above information is complete and true to the best of my knowledge.						
Signature _____				Date _____		

NOTICE OF PRIVACY PRACTICES

<p>I acknowledge being made aware of the Provider's notice of privacy policies. I consent to the Provider's use of protected health information as described in the notice for treatment, payment, or health care operations. I understand that I must provide separate authorization before any other disclosures may be made. Also, I agree to allow the Physician or staff members to remind me of an appointment or notify me of test results after identifying themselves.</p>	
Signature _____	Date _____

<p>REQUEST FOR RESTRICTIONS:</p> <p>I request that my protected health information not be disclosed to the following: _____</p> <p>No Restrictions</p>
