PATIENT INFORMATION SHEET

Please PRINT the following information

Patient Name: ____ Date of Birth: _____-______-______
Sex: Male ___ Female ___ Age: _________ SS#: _________-________-_______
Mailing Address: ____
____

Home Phone: (___) ______-_________ Cell Phone: (___) ______-_________
Pharmacy: ______________________________ Pharmacy: (___) ______-_________

****_we send our prescriptions electronically_****

Occupation: ______________________________ Marital Status: S___ M___ W___ D___
Work Phone: (___) ______-_________ If married, name of spouse: ______________________

PAYMENT INFORMATION: Who is responsible for payment: ________________________________

If not the patient please provide the name, address, and phone number for the person responsible for payment:

Payer: ____________________________ Mailing Address: ____
Payer Phone: (___) ______-_________ ____

Whom may we thank for referring you to us? ______________________________

PRIMARY CARE DOCTOR:

Physician Name (NOT the name of the group): ____

If your primary care has more than one location, please list the following:

Mailing Address: ____ Phone: (___) ______-_________
____

INSURANCE INFORMATION: *Please present insurance cards to the receptionist at time of check in.*

Who is the holder of the insurance policy?

_____ Self _____ Spouse _____ Parent

If other than the patient, please provide policy holder's full name and date of birth.

Policyholder: ____ Policyholder DOB: _____-______-______

By signing the following I authorize the payment of medical benefits to myself or the named provider for professional services rendered. I also authorize the release of any medical information necessary to process this claim. For those patients, applicable co-payments will be collected at the time of service. If no insurance information is available at the time of your appointment, payment will be expected, in full, at the time of service.

X ____ Date: _________________

HIPAA- Receipt of Notice of Privacy Practices- Acknowledgement: Dr. Brad Amos' office has copies of the Notice of Privacy Practices available to all patients in the waiting room. Our staff can also provide you a copy. Dr. Amos' office requires permission from all patients over the age of 18 to release information regarding your care to anyone other than yourself (including family, friends, and spouses)

Please check one of the following below:

_____ I DO NOT give permission to discuss my care with anyone other than myself, except for situations described in the Notice of Privacy Practices.

_____ Dr. Amos' office can discuss any / all aspects of my personal health information to the following:

Name: _____________________________________ Relationship: ________________ Phone: (___) _____-_________
Name: _____________________________________ Relationship: ________________ Phone: (___) _____-_________