THOMAS F. CARMEN, M.D. AND ASSOCIATES
1500 Village Run Road, Suite 308
Wexford, PA 15090
Phone: 724-934-1900 Fax: 724-934-3388

PATIENT INFORMATION

First Name	Middle	Last Name	Birth Date	Age	Gender

Address: ______________________________ **City/State/Zip:** ______________________________

Home Phone: __________________ **Cell Phone:** _________________ **Work Phone:** _____________

E-mail address: ____

Employer: ________________________________ **Occupation:** __________________________

The Federal Government requires this information for Electronic Medical Records. You have the right to choose "declined".

Race :
- ☐ White / Caucasian
- ☐ Black / African American
- ☐ Asian
- ☐ Native Hawaiian / Other Pacific Islander
- ☐ American Indian / Alaska Native
- ☐ Other
- ☐ Declined / Unknown

Ethnicity :
- ☐ Spanish / Hispanic Origin
- ☐ Not of Spanish / Hispanic Origin
- ☐ Declined / Unknown

Primary Language: __________________________

Marital Status: ______________________________

Person/guarantor responsible for payment of services (if different from patient)

First Name	Middle	Last Name	Birth Date	Age

Address ____________________________________ **City/State/Zip** ______________________

Home Phone: ___________________ **Cell Phone:** ________________ **Work Phone:** ____________

Employer: ______________________________ **Occupation:** ________________________

Emergency Contact (not within the same household)

Name	Emergency Number (s)	Relationship to patient

I hereby authorize Thomas F. Carmen, M.D. and Associates to release any medical information required in the course of examination and treatment. I authorize payment directly to Dr. Thomas F. Carmen, M.D. and Associates any charges due for services rendered. I recognize and accept responsibility for services rendered regardless of insurance coverage. The medical providers will perform / order only those tests medically necessary. It is my responsibility to determine if my insurance will cover these tests. I authorize this office to use FAX and EMAIL as a means of rapid communication with other physician's offices, pharmacies, laboratories, and insurance companies that are pertinent to my care. I understand that this office follows HIPAA protocols and protects my privacy as a patient. I have read and understand the above statements.

Signature: ____ **Date:** ______________