PATIENT INFORMATION SHEET

FULL LEGAL NAME _____
Last First Middle

ADDRESS _____
Street City State Zip Code

DOB _____**SS#** _____**GENDER** _____ **MARITAL STATUS** _____

PATIENT PHONE _____**CELL PHONE** _____

EMAIL ADDRESS _____

EMERGENCY CONTACT _____

_____
Street City State Zip Code

_____
Phone Number Relationship to Patient

PATIENT EMPLOYER _____

_____
Street City State Zip Code

_____
Work Number Hours Worked

PATIENT DRIVERS LICENSE _____

PRIMARY INSURANCE _____

SECONDARY INSURANCE _____

SPOUSE'S NAME _____

DOB_____**SS#**_____

EMPLOYER _____

IS PATIENT A MINOR CHILD: ○ **YES OR NO**
PARENT NAME _____

DOB _____ **SS#** _____

EMPLOYER_____

I GIVE MY WRITTEN CONSENT TO HAVE SERVICES PERFORMED AND TREATMENT RENDERED TO ME BY THE DOCTORS AND MEDICAL STAFF OF DURBIN FAMILY PRACTICE.

_____
Patient name (print) Patient's signature Date

RELEASE OF INFORMATION: I AUTHORIZE THE PHYSICIAN TO RELEASE TO MY INSURANCE CO. ANY INFORMATION AQUIRED IN THE COURSE OF MY EXAM OR TREATMENT & PERMIT PAYMENT DIRECTLY TO PHYSICAIN BENEFITS DUE ME FOR SERVICES RENDERED. I RECOGNIZE & ACCEPT PERSONAL REPPONSIBILITY ANY BALANCE REMAINING AFTER BENEFITS. I'M ALSO AWARE OF $15.00 FEE FOR APPOINTMENTS CANCELLED OR BROKEN WITHOUT 24 HR ADVANCE NOTICE.

SIGNATURE _____ **DATE** _____

PRIVACY PRACTICES ACKNOWLEDGEMENT:

I HAVE RECEIVED THE NOTICE OF PRIVACY PRATICES AND I HAVE BEEN PROVIDED AN OPPORTUNITY TO REVIEW IT.

SIGNATURE _____**DATE**_____