

Name: \_\_\_\_\_ SS#: \_\_\_\_\_ Birth date: \_\_\_\_\_

Driver License #: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Cell #: \_\_\_\_\_ E-mail: \_\_\_\_\_

Address: \_\_\_\_\_ Apt. #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone #: \_\_\_\_\_

Emergency Contact Name (list one that does not live with the Patient): \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

Responsible Party's Name (if other than Patient / or Patient is under the age of 19): \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Driver License #: \_\_\_\_\_ Birth date: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Patient Record of Disclosures**

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondences to the individual's office instead of home.

**I wish to be contacted in the following manner:**

\_\_\_ Home Telephone \_\_\_\_\_  
\_\_\_ OK to leave message with detailed information  
\_\_\_ Leave message with call back number only

Work Telephone \_\_\_\_\_  
\_\_\_ OK to leave message with detailed information  
\_\_\_ Leave message with call back number only

\_\_\_ Written Communication  
\_\_\_ OK to mail to my home address  
\_\_\_ OK to mail to my work/office address  
\_\_\_ OK to fax to this number \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Responsible Person's Signature: \_\_\_\_\_ Relationship: \_\_\_\_\_