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PLEASE COMPLETE BOTH SIDES OF PAGE

PATIENT INFORMATION

LEGAL NAME _____ DATE OF BIRTH ____/____/____
FIRST MI LAST

ADDRESS _____
STREET CITY STATE ZIP

HOME PH (____) _____ CELL (____) _____ WORK (____) _____

EMAIL _____ EMPLOYER NAME: _____

MALE FEMALE SSN _____

SPOUSE'S NAME _____ EMPLOYER _____ PHONE _____

PRIMARY CARE PHYSICIAN _____ REFERRING PHYSICIAN _____

INSURANCE

NAME OF PRIMARY INSURANCE COMPANY _____ ID# _____

SUBSCRIBER'S NAME _____ DOB _____

NAME OF SECONDARY INSURANCE COMPANY _____ ID# _____

SUBSCRIBER'S NAME _____ DOB _____

NAME OF TERTIARY INSURANCE COMPANY _____ ID# _____

SUBSCRIBER'S NAME _____ DOB _____

RESPONSIBLE PARTY

SELF OTHER PARENT/GUARDIAN (please fill out pediatric section)

RESPONSIBLE PARTY NAME _____ RELATIONSHIP _____

ADDRESS _____ PHONE NUMBER (____) _____

DATE OF BIRTH _____ SSN _____

PEDIATRIC PATIENTS ONLY: Please check box for responsible party

MOTHER'S NAME _____ EMPLOYER/WORK PH _____

(IF DIFFERENT) ADDRESS _____

STREET CITY STATE ZIP

FATHER'S NAME _____ EMPLOYER/WORK PH _____

(IF DIFFERENT) ADDRESS _____

STREET CITY STATE ZIP

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information ("PHI"). I understand that I may request a copy of the *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address provided to obtain a current copy of the *Notice of Privacy Practices*. I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operation. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

(CONTINUED ON BACK SIDE, PLEASE FLIP OVER)

★ **PART A: Authorization to disclose medical/financial information to individuals other than the patient, primary care physician and referring physician:**

I hereby authorize Dr. Richard M. Greene's office to disclose any pertinent medical and/or financial information to the family members, friends and/or doctors listed below in reference to my care or payment for such care:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Our office may contact you by telephone regarding appointments, financial and/or medical information. **Please check one of the following:

- Yes, it is okay to leave messages on my home and/or cell No, do not leave messages on my home and/or cell

Comments/Restrictions: _____

** Our office has the ability to send your appointment reminders via text message, **please check one of the following:**

- Yes, it is okay to text me an appointment reminder No, I prefer a phone call regarding my appointment

★ **PART B: Notice of Privacy Practices Acknowledgement:**

Acknowledgement signed by: _____

Printed Name – Patient or Parent/ Legal Guardian of patients 11 or younger

Signature: x _____ Date _____

Patient or Parent/ Legal Guardian of patients 11 or younger

Relationship to Patient (if other than patient): _____

★ **PART C: MEDICAL HISTORY QUESTIONNAIRE**

1. Are you allergic to any medication(s)? ___yes ___no

If yes, please list the medications you are allergic to _____

2. Please list the names of medications that you are currently taking:

MEDICATION	DOSAGE	REASON
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. Do you take aspirin or blood thinners? ___yes ___no

If yes, _____

(Name of medication)

5. Have you ever been treated for any form of cancer? ___yes ___no

If yes, was it metastatic? ___yes ___no

6. Do you smoke? ___yes ___no ___former smoker

7. Do you drink alcohol?

___daily ___occasionally ___rarely ___none