**Patient Information**

Last Name: _____ First Name:_____ Middle Initial: ____ Date of Birth ____/____/____

Marital Status: Married____ Single____ Divorced____ Widowed____ Separated____ Sex: Male____ Female____

Address: _____ Apt #_____ City_____ State _____ Zip _____

Social Security Number _____-___-_____ **Best contact No**. _____cell / home / work

Alternate No. _____ E-mail_____

***How would you like to be contacted for appointment reminders? (must mark at least one method)**
**Text ____ Voicemail ____ E-mail ____**

**We can TEXT patients some information regarding LAB Results, Prescriptions, Medications, Referrals and other general medical information. Would you like to be notified this way?**

**NO ____ YES ____ if yes, to what number (_____) _____ -_____.**

**Insurance Information:**

Insurance Co. _____ Policy/ID No. _____ Group No. _____

**Do you have Secondary Insurance:** _____ No _____ Yes (Please hand card to the person helping you)

**Emergency Contact Information**

Name: _____ Phone No _____

**Pharmacy Information**

Pharmacy Name: _____ Phone No._____

Address: _____ City_____ State_ ____ Zip _____

Mail Order Pharmacy: _____ Phone No. _____

**Disclosure Information**

Is there someone we have permission to contact or share medical information with on the patient's behalf?
Yes____ No____ (if yes, please list name(s)

_____ _____ _____

**PF-200 Acknowledgement of Receipt of Notice of Privacy Practices**
Our practice reserves the right to modify the privacy practices outlined in the notice.
I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed by **Dr. Van Meter or Dr. Smith.** I understand I am entitled to receive a copy of your Notice of Privacy Practices.

_____ _____ _____
Name of Patient (Print) Signature Date

_____ _____
Signature of Patient Representative Relationship to Patient