

## Patient Information

Date:

Last Name : \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Marital Status: S M P W D (circle one)  
Street \_\_\_\_\_ Age \_\_\_\_\_ Social Security # \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ e-mail address \_\_\_\_\_  
Home Telephone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_  
Employer \_\_\_\_\_  
Employer Address \_\_\_\_\_  
Employer Telephone # \_\_\_\_\_  
If Student: School Name \_\_\_\_\_ Full Time / Part Time (circle one)

### ***Parent / Spouse / Partner***

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_  
Street \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone # \_\_\_\_\_ Occupation \_\_\_\_\_  
Employer \_\_\_\_\_  
Employer Address \_\_\_\_\_  
Employer Telephone # \_\_\_\_\_

### ***Emergency Contact Information***

Emergency Contact #1 \_\_\_\_\_ Phone # \_\_\_\_\_  
Relationship \_\_\_\_\_  
Emergency Contact #2 \_\_\_\_\_ Phone # \_\_\_\_\_  
Relationship \_\_\_\_\_

### ***Primary Insurance Information***

Company Name \_\_\_\_\_  
Address \_\_\_\_\_  
Telephone # \_\_\_\_\_  
Identification # \_\_\_\_\_ Group # \_\_\_\_\_  
Insured's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

### ***Secondary Insurance Information***

Company Name \_\_\_\_\_  
Address \_\_\_\_\_  
Telephone # \_\_\_\_\_  
Identification # \_\_\_\_\_ Group # \_\_\_\_\_  
Insured's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Are there any other health insurance benefit plans? Yes No (Circle one)

I certify that the above information is correct

Signature

Form updated 6/8/10

## **Acknowledgement of Receipt of Privacy Practices**

I have been presented with a copy of Robert B. Albee, Jr., MD & Associates, LLC's Notice of Privacy Policies detailing how my protected health information may be used and disclosed as permitted by Federal and State Law. I understand the Notice, and to the extent necessary, I authorize disclosure of all my medical information with the following restrictions:

The following individuals have unrestricted authorized access to my medical information:

This authorization will remain in effect until revoked by me in writing or to the extent action has already been taken. Further, I permit a copy of this authorization to be used in place of the original.

Moreover, I assign all medical/surgical benefits to be paid to Robert B. Albee, Jr., MD & Associates, LLC for services furnished to me by their physicians or suppliers.

Additionally, I authorize any holder of my medical information to release it to Robert B. Albee, Jr., and Associates without restrictions.

*Signed:*

*Date:*

If not signed by patient, please indicate relationship to patient (e.g. spouse).

*Relationship:*

*Witnessed by:*

*Updated 6/8/10*

***Patient's Medication Information***

		Date	
Last Name:	First Name:	Middle Initial:	
Date of Birth			
Street			
City	State	Zip	e-mail address
Home Telephone		Cell Phone	

***Please list all ALLERGIES you may have***

- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10

***Please list all MEDICATIONS you are presently taking.***

<i>Name of medication</i>	<i>Dosage</i>	<i>Frequency</i>
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		update 6/8/10
16		