

PATIENT INFORMATION

Fam I.D.#: _____
 (office use only)

PATIENT (or child's parent)

Today's date _____

Name _____
Last First M.I.

Birth date _____
age

Address _____
Street Apt. No.

_____ City State Zip

Land line (_____) _____
A.C. Number

Cell phone (_____) _____
A.C. Number

E-mail address _____
 How did you hear about our practice? _____

Medication Allergies _____

Marital status _____ How long? _____

Soc. Sec. No: _____

Employer name _____

Emp. add. _____
street city state zip

Emp. phone (_____) _____
A.C. Number

Occupation _____

Insurance Co. _____

Address _____
street city state zip

_____ Ins ID No. Policy/Group No.

Would you like to receive an annual postcard to remind you about your Pap smear? Yes No

SPOUSE

Name _____
Last First M.I.

Birth date _____
age

Address _____
Street (if different) Apt. No.

_____ City (if different) State Zip

Cell Phone (_____) _____
A.C. Number

Medication Allergies: _____

E-mail Address: _____

Soc. Sec. No: _____

Employer name _____

Emp. add. _____
street city state zip

Emp. phone (_____) _____
A.C. Number

Occupation _____

Insurance Co. _____

Address _____
street city state zip

_____ Ins ID No. Policy/Group No.

Childrens' names: **OLDEST CHILD FIRST**

Childrens' names: OLDEST CHILD FIRST	Birth date	Medication Allergies	ID# (Off. use only)
First M.I. Last (if different) Male <input type="checkbox"/> Female <input type="checkbox"/>	month/date/year		
Male <input type="checkbox"/> Female <input type="checkbox"/>			
Male <input type="checkbox"/> Female <input type="checkbox"/>			
Male <input type="checkbox"/> Female <input type="checkbox"/>			
Male <input type="checkbox"/> Female <input type="checkbox"/>			
Male <input type="checkbox"/> Female <input type="checkbox"/>			
Male <input type="checkbox"/> Female <input type="checkbox"/>			

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize George B. Elvove, M.D., P.C. to release any information to my Insurance Company acquired in the course of examination or treatment. This includes any information about psychiatric diagnoses or treatments and HIV status. I authorize benefits to be paid directly to my attending physician. I understand that I am responsible for payment and in the case of default agree to pay all collection costs (35%) and the maximum interest permitted by law. I authorize Dr. Elvove to provide medical care to myself and all members of my family. I understand that I am entitled to access my medical records at any time and to copy, amend, or make corrections if I deem necessary to improve their accuracy. My signature below indicates that I have read, understood, and agree with these statements.

SIGNATURE _____