

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

Phone (_____) _____
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.

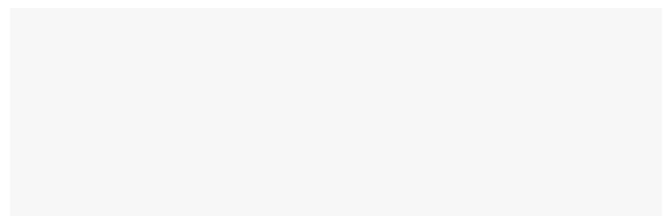
Birth date _____
age

Address _____
Street (if different) Apt. No.

City (if different) State Zip

Phone (_____) _____
A.C. Number (if different)

Medication Allergies: _____



Soc. Sec. No: _____

Employer name _____

Emp. add. _____
street city state zip

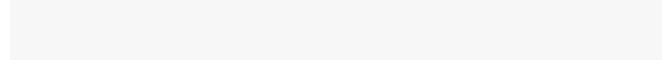
Emp. phone (_____) _____
A.C. Number

Occupation _____

Insurance Co. _____

Address _____
street city state zip

Ins ID No. _____ Policy/Group No. _____



Childrens' names: OLDEST CHILD FIRST	Birth date	Medication Allergies	ID# (Off. use only)
_____ <small>First M.I. Last (if different)</small>	_____ <small>month/date/year</small>	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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 _____