PATIENT INTRODUCTION FORM

Today's Date: ________________________

Last Name:	**MI:** **First Name:**
Home Address:	**City:** **State:** **Zip:**
Date Birth: Age:	Social Security Number:
Height: Weight:	**Who Referred You to Our Office**:
Employer's Name:	Marital Status (Circle): Single, Married, Divorced, Widowed
Occupation:	Name of Family Physician:

☐ **YES,** ☐ **NO I authorize the following telephone numbers** ☐ **YES,** ☐ **NO I authorize the use of my address for mailing** ☐ **YES,** ☐ **NO I authorize the use of my e-mail address** **Home:**______________________ **Work** __________________________ **Cell / Pager (Please circle to indicate):** ________________________ **E-mail:** ____ Indicate if you have a preferred mailing address: _____________________ ____ **Signature:**____________________________ **Date:**_________________ Expiration Date/Event for Authorization: ☐ No expiration date ☐When I have discontinued treatment and all bills have been paid. ☐ Date: _______________________	Our office needs to leave messages, return telephone calls, and send office mail to your home address as part of our normal practice. Federal/State Health Insurance Portability and Accountability Act (HIPAA) patient privacy laws allow you to restrict doctor/staff communication with you or to contact you through alternative means. Please list telephone numbers that are acceptable for our office to call. Your agreement will allow our office to use your name and the indicated mailing address for sending reminders about scheduled appointments, re-activation letters, sending birthday/holiday cards, office newsletters, or providing information about other health related matters that may be of interest to you, billing statements/questions, status of your account, and other office related matters. We will use your home address, noted above, unless you indicate a preferred address. You may indicate a preferred mailing address by indicating so on this form. This authorization may be revoked by you at any time, by advising our office (Privacy Officer) of this revocation in writing. If you choose not to sign this authorization, this will not have any adverse effect on your treatment, eligibility for benefits, enrollment, or payment.

The HIPAA information has been provided to me by this office. ____
(Signature and date)

IS THIS VISIT RELATED TO:

☐ Work Related Injury/Symptoms	☐ Motorcycle-Bicycle Injury	☐ Other (Describe):____________
☐ Sport or Recreational Injury	☐ Home Injury Symptoms	___________________________
☐ Motor Vehicle Crash Injury	☐ Non-Injury Pain/Symptoms	

Name, Address, Relationship, and Telephone Number of your nearest adult relative (for emergencies):

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I am a responsible party and agree to pay for any outstanding bills incurred in this office. It is my responsibility to pay any deductible, co-insurance, and/or any other balances not paid by my health insurance carrier.

PATIENT SIGNATURE ______________________________________ **DATE** _________________
(Minors must have parent's signature.)

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