ACADEMIC MEDICAL ASSOCIATES

PATIENT INFORMATION

Patient's Name (First, Middle, Last): _____

Address: _____

City:_____ State:_____ Zip Code: _____ Email: _____

Main Contact#: _____ Alternate#:_____ Work#: _____

Date of Birth: _____/_____/_____ Sex: ___Male ___Female SS#: _____

Marital Status: _Single_Married_Divorced_Widowed Occupation:_____

Email Address: _____

Patient Referred By: _____ Spouse's Name: _____

Spouse's Date of Birth: _____ Main Contact #: _____

Preferred Pharmacy: _____ City: _____ Phone #: _____

Intersection: _____

INSURANCE INFORMATION

Primary Insurance:_____ Policy/ID# _____

Name of Policy Holder:_____ DOB: _____/_____/_____ Group/Acct #:_____

Employer: _____ Employer Address: _____

City: _____ State: _____ Zip Code: _____ Work #: _____

Secondary Insurance:_____ Policy/ID# _____

Name of Policy Holder:_____ DOB: _____/_____/_____ Group/Acct #:_____

Employer: _____ Employer Address: _____

City: _____ State: _____ Zip Code: _____ Work #: _____

PATIENT PREFERENCE REGARDING COMMUNICATION OF HEALTH INFORMATION

I hereby give my permission to Academic Medical Associates to disclose and discuss information related to my medical condition(s) to/with the following persons:

Name: _____ Relationship: _____ Ph#:_____
Name: _____ Relationship: _____ Ph#: _____
Name: _____ Relationship: _____ Ph#: _____

___ I do not wish to give consent for any person to have access to any information regarding my medical condition(s).

Emergency Contact: _____ Relationship: _____ Ph#: _____

This authorization shall remain in effect unless otherwise revoked in writing, I understand that requests for medical information from persons not listed above will require a specific authorization prior to disclosure of any records.

Signature of Patient or Legal Representative: _____

Printed Name and Relationship: _____ Today's Date: _____