ACADEMIC MEDICAL ASSOCIATES

PATIENT INFORMATION					
Patient's Name (First, Middle, Last)	:				
Address:					
City:	_ State: Z	lip Code:	_ Email:		
Main Contact#:	Alterna	ate#:	\	Nork#:	
Date of Birth:///	Sex:Male _	Female SS#:			
Marital Status:SingleMarriedDivorcedWidowed Occupation:					
Email Address:					
Patient Referred By:		Spouse's Nar	ne:		
Spouse's Date of Birth:	Main Contact #:				
Preferred Pharmacy:	City:	Phone #:			
Intersection:					
INSURANCE INFORMATION					
Primary Insurance:		Policy/ID7	#		
Name of Policy Holder:		_ DOB://	Group/	Acct #:	
Employer:		_ Employer Address:			
City:	_ State:	_ Zip Code:	_ Work #: _	<u>_</u> _	
Secondary Insurance:	dary Insurance: Policy/ID#				
Name of Policy Holder:		_ DOB://	Group/	Acct #:	
Employer:		_ Employer Address:			
City:	_State:	_ Zip Code:	_ Work #: _		
PATIENT PREFERENCE REGARDING CC I hereby give my permission to Acac medical condition(s) to/with the follo Name:	lemic Medical A owing persons:	ssociates to disclose an	d discuss ir		
Name:	Rela	ationship:		Ph#:	
Name:I do not wish to give consent for condition(s).	any person to h	auonship: ave access to any infor	mation reg	garding my medical	
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 Represe	entative:				
Printed Name and Relationship:		То	oday's Da	te:	