WELCOME TO OUR OFFICE

(PLEASE PRINT CLEARLY)

PATIENT NAME:_____SS# _____-____-_____
(LAST) (FIRST) (MIDDLE)

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

1st CONTACT PHONE#: (_____)_____-_____ 2nd CONTACT PHONE#: (_____)_____-_____

DATE OF BIRTH: ____/____/_____(MM/DD/YEAR) MALE_____FEMALE_____

MARRIED_____ DIVORCED_____ SINGLE_____ WIDOWED_____ STUDENT STATUS_____

EMPLOYER:_____ PHONE#: (_____)_____-_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

SPOUSE NAME:(OR LEGAL GUARDIAN if a minor)_____

DATE OF BIRTH: ____/____/_____(MM/DD/YEAR) SS#(Spouse/Guardian)_____-____-_____

HIS/HER EMPLOYER:_____ WORK PHONE#: (_____)_____-_____

EMERGENCY CONTACT NAME #1:_____RELASHIONSHIP TO YOU:_____

1st EMERGENCY PHONE#: (_____)_____-_____ 2nd EMERGENCY PHONE#: (_____)_____-_____

EMERGENCY CONTACT NAME #2:_____RELASHIONSHIP TO YOU:_____
(THAT DOES NOT LIVE IN YOUR HOUSEHOLD)

1st EMERGENCY PHONE#: (_____)_____-_____ 2nd EMERGENCY PHONE#: (_____)_____-_____

WHOM MAY WE THANK FOR REFERRING YOU:_____

PLEASE PROVIDE ALL INSURANCE INFORMATION TO THE RECEPTIONIST.

*I understand and agree that health and accident insurance are an arrangement between an insurance carrier and me. Furthermore, I understand that Dinkelmann Health Center will prepare any necessary reports and forms to assist me in making collection from the insurance carrier. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment at the time the services are performed. I also agree that if a dispute regarding my treatment, diagnosis or payments occurs, neither party will sue the other, but rather settle for arbitration to solve the grievances. *I hereby give permission to the doctor and the clinic to release any information requested by my insurance carrier, acquired in the course of my examination and treatment. *I hereby give permission to the doctor to administer treatment and perform such general procedures, as he may deem necessary in the diagnosis and treatment of my condition.

I HAVE READ AND AGREE TO THE ABOVE STATEMENTS.
SIGNATURE:_____DATE:_____/_____/_____

ACKNOWELEDGMENT OF RECEIPT OF DINKELMANN HEALTH CENTER PRIVACY NOTICE

DATE:_____NAME:_____

By my signature below I confirm that I have received a copy of Dinkelmann Health Center Privacy Notice. This notification refers to my Protected Health Information (PHI), under the Health Insurance and Accountability Act of 1996 effective as of April 2003.

_____
Signature