PARK WEST
FAMILY MEDICINE

PATIENT INFORMATION

In order to serve you properly, we need the following information. All information will be confidential. Please print.

Patient name (Last, First Middle) _____ SSN _____

Birth date _____ Home phone _____ Cell phone _____

Gender at birth _____ Preferred pronouns _____ Marital status: ☐ Married ☐ Divorced ☐ Widowed ☐ Single

Address _____ City _____ State _____ ZIP _____

Patient email _____ Pharmacy No. _____

RESPONSIBLE PARTY (Who is to receive the bills if other than self)

Name _____ Birth date _____ Phone _____

Address _____ City _____ State _____ ZIP _____

Employer _____ Work phone _____

Park West Family is not responsible to mediate any legal agreements regarding financial responsibility. Initial here _____

INSURANCE INFORMATION

Insurance company _____ ID# _____ Group# _____ Effective date _____

Name of insured _____ Relationship to patient _____

Birth date _____ SSN _____ Date employed _____

Name of employer _____ Work phone _____

Do you have any additional insurance? ☐ Yes ☐ No If yes, please complete the following:

Name of insured _____ Relationship to patient _____

Birth date _____ SSN _____ Date employed _____

Name of employer _____ Work phone _____

Employer address _____ City _____ State _____ ZIP _____

PATIENT INFORMATION (Cont'd)

I authorize the release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable by me directly to the doctor.

_____ _____

Signature of patient or parent of minor Date

COMMUNICATION METHODS

We will use the minimum language necessary when disclosing your diagnosis on referrals, lab requests and mail-in prescriptions. May we contact you by telephone or mail as usual? If we leave a message on your telephone, it will be brief. For example, "Call doctor's office at (773) 929-7410." If you do not want us to use these methods, please state so below.

You request that we communicate with you about your health care in the following manner. Please check the appropriate boxes to instruct us of the method of relace we can use:

☐ In case of emergency, call _____ Relationship to patient _____

Home phone _____ Cell phone _____

☐ You may contact me by mail

☐ You may contact me by phone (Note: Caller ID may appear)

☐ You may release information about me to my friends and family whom I've listed below:

Full name _____ Phone number _____

Full name _____ Phone number _____

Full name _____ Phone number _____

Full name _____ Phone number _____

NOTICE OF PRIVACY PRACTICES (HIPAA)

I have read and received the notice of privacy practices/HIPAA notice and rules.

_____ _____ _____

Signature of patient Print name Date

_____ _____ _____

Signature of parent/legal guardian Print name Date

_____ _____ _____

Signature of witness Print name Date