



PATIENT INFORMATION

Name: _____ Social Security #: _____
Circle One: Single/Married/Divorced/Widowed/Separated Birth Date: _____
Mailing Address: _____
City: _____ State: _____ Zip: _____
Home #: _____ Cell #: _____ Email: _____
Spouse's Name: _____ SSN#: _____ Birth Date: _____
Emergency Contact Name: _____ Emergency #: _____
Primary Care Physician: _____ Referred By: _____

HIPAA DISCLOSURE

Do you wish any person, other than yourself, to have access to your medical record? YES NO
If YES, who? _____ Relation: _____

EMPLOYMENT INFORMATION

Your Employer: _____ Phone Number: _____
Address: _____
Spouse's Employer: _____ Address: _____ Phone: _____

INSURANCE INFORMATION

Insurance Company: _____ Policy I.D. Number: _____
Group Number: _____ Address: _____
Medicaid Number: _____ Kenpac Doctor: _____
Do you have additional insurance coverage? YES NO
Company Name: _____ Policy I.D. Number: _____
Group Number: _____ Address: _____

INSURANCE AUTHORIZATION

I hereby authorize payment directly to GHAA PSC of the surgical and/or medical benefits otherwise payable to me for their services. I further authorize them to release any information concerning my exam and treatment to the insurance company and/or referring physician.

Patient/Insured Signature: _____ Date: _____

PATIENT HIPAA ACKNOWLEDGEMENT

Thank you for taking time to review how we are carefully using your health information. If you have any questions, please ask. If not, we would appreciate you acknowledging your receipt of our privacy policies with your signature below. Thank you.

Patient Signature: _____ Date: _____