

NEW UPDATE

# ADULT PATIENT INFORMATION

PLEASE PRINT

NAME \_\_\_\_\_ AGE \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_  
 ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
 HOME # \_\_\_\_\_ WORK # \_\_\_\_\_ CELL # \_\_\_\_\_  
 EMAIL ADDRESS \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ ( ) MALE ( ) FEMALE  
 OCCUPATION \_\_\_\_\_ EMPLOYER / SCHOOL NAME \_\_\_\_\_  
 EMPLOYER ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

## Spouse Information

SPOUSE'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_  
 ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
 EMPLOYER \_\_\_\_\_ WORK # \_\_\_\_\_ CELL # \_\_\_\_\_  
 EMAIL \_\_\_\_\_ MAY WE LEAVE A CONFIDENTIAL MESSAGE/TESTS RESULTS WITH SPOUSE ON THEIR:  
 HOME PHONE  CELL PHONE  (CHECK ALL THAT APPLY)

## Person to Notify in Case of Emergency

NAME \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_  
 HOME # \_\_\_\_\_ WORK # \_\_\_\_\_ CELL # \_\_\_\_\_

## Insurance Information

<b>PRIMARY INSURANCE:</b>		GROUP #	POLICY # / I.D. #:
ADDRESS:		PHONE #:	EFFECTIVE DATE:
POLICY HOLDER'S NAME:		RELATIONSHIP TO PATIENT:	
DATE OF BIRTH:	SEX:	SOCIAL SEC. #:	SUBSCRIBER EMPLOYER INFO:
<b>SECONDARY INSURANCE:</b>		GROUP #:	POLICY#:
ADDRESS:		PHONE #:	
POLICY HOLDER'S NAME:		SOCIAL SEC. #:	

## Authorization Release for Tests Results/ Confidential Information

**MAY WE LEAVE CONFIDENTIAL MESSAGES/TESTS RESULTS ON:**  (CHECK ALL THAT APPLY)

- HOME ANSWERING MACHINE  VOICE MAIL  WORK VOICE MAIL  CELL PHONE  
 FOLLOWING PERSON(S)

NAME	HM/WK #	CELL #
NAME	HM/WK #	CELL #
NAME	HM/WK #	CELL#

CONTINUE ON BACK→

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE

**PLEASE LIST OTHER HOUSEHOLD MEMBERS**

NAME	AGE	NAME	AGE	NAME	AGE
NAME	AGE	NAME	AGE	NAME	AGE

**AUTHORIZATION**

I voluntarily consent to medical treatment for myself to the Providers at the office of Dr. William K. Bostock. I give consent to Dr. William Bostock or designated staff's use and disclosure of any oral, written, or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment, and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

I understand that I have a right to have provided to me and review Dr. William Bostock's Notice of Privacy Practices before signing this document. The Notice of Privacy Practices is also posted for review in the reception area. This notice describes the types of uses and disclosures of protected health information that will occur in my treatment, payment of my bills or in the practice of health care operations of the practice.

Dr. William Bostock reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notion of privacy practices by calling the office and requesting that a revised copy be sent to me or asking for one at the time of my next appointment.

I hereby authorize payment of medical benefits to Dr. William Bostock for any services rendered. I agree to be responsible for payment of all services rendered on my behalf. I understand that payment is due at the time of service. I understand that I am responsible for the bill should my insurance company not pay.

**A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE VALID AS THE ORIGINAL**

\_\_\_\_\_  
**Patient or Legal Guardian's Signature**

\_\_\_\_\_  
**Date**