Demographics Form, HIPAA
& Acknowledgement of Review of Notice of Privacy Practices

Please Print

Name: _____ Salutation: _____ ☐ Male ☐ Female
First Middle Last

Address: _____ City: _____ State: _____ Zip: _____

D.O.B: ____/____/_____ Age: _____ Social Security #: _____ Marital Status: S M D W
Circle

Home Phone: (____) _____ E-Mail Address: _____

Cell Phone: (____) _____ Fax Phone: (____) _____

Employer: _____ Work Phone: (____) _____

Emergency Contact (Friend/Relative): _____ Phone: (____) _____

Parent/Spouse Name: _____
First Middle Last

Insurance Co.:_____ ID#_____ Group #_____

Subscriber's Name: _____ Subscriber's Date of Birth: ____/____/_____

Person responsible for the bill? ☐ Self ☐ Spouse ☐ Other

Name (if different from above): _____

How did you hear about our center? _____
_____
_____

PATIENT RECORD OF DISCLOSURES

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document if requested.

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

Patient's Signature: _____ **Date:** _____