INFECTIOUS DISEASES ASSOCIATES, PLLC

CONSENT TO USE OR DISCLOSE HEALTH INFORMATION FOR THE PURPOSE
OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

PATIENT INFORMATION: (Please Print)

PATIENT NAME: ____
(Last) (First) (Middle) (Maiden)

SOCIAL SECURITY NUMBER: ______________________ Male_______ Female_______

RACE:(optional) African American_____ White_____ Hispanic_____ Asian_____ Other_________

ADDRESS: ____
(Street) (City) (State) (Zip)

PHONE: (______) _________________DOB:_______________MARITAL STATUS: M S W D

CELL PHONE: (_____) _______________________WORK PHONE: (______)_________________

EMAIL ADDRESS: ____

EMPLOYER NAME & ADDRESS: ____

REFERRING PHYSICIAN: ____

GUARDIAN NAME: (IF PATIENT UNDER 18) ______________________________

ADDRESS: ______________________________ PHONE: (______)_______________

IN CASE OF EMERGENCY: (NEAREST RELATIVE NOT LIVING WITH YOU)

NAME: ____

RELATIONSHIP: ______________________________ PHONE: (______)_________________

PRIMARY INSURANCE: _______________________ PHONE: (______)___________________

BILLING ADDRESS: ____

POLICY NUMBER: ____________________________ GROUP NUMBER:___________________

CARDHOLDER NAME & RELATION TO PATIENT: ______________________________

DOB: ____________________ SOCIAL SECURITY NUMBER: ____________________________

EMPLOYER: ____

Please provide your insurance card(s) to the receptionist when you register. It is the policy of Infectious Diseases Associates, PLLC to collect co-payments at time of service.