



Date: \_\_\_\_\_

**Patient Information:**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_  
                    First                    Middle                    Last                    M          D          Y

Social Security Number: \_\_\_\_\_ Age: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Marital Status: \_\_\_ Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Widowed \_\_\_ Domestic Partnership

**Responsible Party Information:**

Parent/Guardian Name: \_\_\_\_\_

Spouse Name: \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_

\_\_\_\_\_

Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Work Phone #: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

**Referred by:** \_\_\_ Friend \_\_\_ Physician \_\_\_ Other-Please Provide: \_\_\_\_\_

**How did you hear about us?**

\_\_\_ Mail \_\_\_ Friend \_\_\_ Newspaper Ad \_\_\_ Promotional Call \_\_\_ Radio \_\_\_ Insurance

\_\_\_ Yellow Pages \_\_\_ Website \_\_\_ Employer \_\_\_ Health/Senior Fair \_\_\_ Sponsored Event

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

**Reason for Appointment Today:**

\_\_\_\_\_

**PLEASE PROVIDE INSURANCE CARD (S) AND DRIVER'S LICENSE TO FRONT OFFICE STAFF**

\*\*\*\*\*PLEASE READ CAREFULLY- MARK BOXES AND SIGN BELOW\*\*\*\*\*

- I give permission to my AudigyCertified™ practice to release information, verbal and written, contained in my medical record and other related information, to my insurance company, case manager, attorney, employer, related healthcare providers, assignees and/or beneficiaries and all other related persons. Information without patient identifiers may be used for quality purposes.
- I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for professional services or purchases rendered.
- I acknowledge that I have reviewed the Health Insurance Portability & Accountability Act (HIPPA) policy of this office. A copy has been provided to me upon request.  
People authorized for this office to speak to regarding your account:  
\_\_\_\_\_
- Detailed messages may be left on home and/or cell phones.
- Detailed messages may not be left on home and/or cell phones.
- I have read all the information on this sheet and have completed the above answers, certify this information is true and correct to the best of my knowledge and hereby give my AudigyCertified™ practice permission to treat my concerns.

**I have read and understand all the above information.**

\_\_\_\_\_  
A copy of this signature is as valid as the original

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent or Guardian if patient is a minor (under 18)

\_\_\_\_\_  
Date

**Your Experience:**

We believe in, and strive to provide, a convenient location with ample parking and expect our staff to always be professional, courteous and helpful. To provide you with the highest level of service, please rate your experience of the following areas (you may also request confidential response card to be mailed to our third party management group):

- Location and accessibility:  Excellent  Average  Poor
- Convenience of appointment times:  Excellent  Average  Poor
- Friendly Greeting:  Excellent  Average  Poor
- Clean and Welcoming Environment:  Excellent  Average  Poor
- Adequate Parking:  Excellent  Average  Poor

What can we do to make your visit more comfortable? \_\_\_\_\_