Over 18 Patient Demographic

Patient (last,first,middle): ______________________________ **Nickname:** ____________________

Date Of Birth: ______________ **Gender** (please circle one)**:** Male Female **Adopted** (please circle one)**:** Yes No

Resides With (please circle one) **:** Mom Dad Both Other ____________________

Ethnicity (please circle one)**:**

Unknown Hispanic or Latino Not Hispanic or Latino Other

Race (please circle one)**:**

American Indian Or Alaskan Native Asian Black or African-American

White Declined to specify Hawaiian Native or Pacific Islander

Preferred Location (please circle one)**:** Marietta Towne Lake Roswell

Preferred PCP: ____

Primary Home Address: **Patient Phone Number:** ____________________

Street: ____

City, State, Zip: ____

Primary Email: ____

Emergency Contact (other than parent):
Name: ______________________________ **Phone:** ____________________

Whom may we contact for the following:

Confirmation calls: ______________________________ **Phone:** ____________________

Clinical Information: ______________________________ **Phone:** ____________________

Billing Information: ______________________________ **Phone:** ____________________

Health Insurance Portability And Accountability Act (HIPAA)

Please sign below that you have been offered the opportunity to review a copy of our HIPPA notice. You are entitled to a personal copy of the notice at any time to keep for you records.

Signature of Patient: ____

As a patient 18 years or older, I have been made aware of my right to privacy. My PHI/EHI (Personal/Electronic Health Information) may be released to:

Please circle one: No one except myself The following person(s) listed below

Name(last,first)**:** ______________________________ **Name**(last,first)**:** ______________________________

Patient Signature: ______________________________ **Date:** ______________________________

****

FOR STAFF USE ONLY
Entered By: ______________________ **Date:** ______________________

LB 12-10-21