

2010 Physical Express Patient Information Form (Please Print)

1) Patient Information

Legal Name (include MI): _____ Date of Birth: ____/____/____
Nickname (if applicable): _____ Social Security: ____-____-____
Email Address (for office use only): _____@_____
Race: _____ Sex (circle): M F Marital status: Married Single Divorced
Mailing address: _____ City _____ St. _____ Zip _____
Employer: _____ Occupation: _____
Phone numbers (Home): (____)____-____ Work: (____)____-____ Cell: (____)____-____

2) Responsible Party (Complete only if patient is a minor. If information is the same as above, write "same"):

Name of guardian(s): _____ Relationship: _____
Home address: _____ City _____ St. _____ Zip _____
Responsible Party's SSN: ____-____-____
Employer: _____ Occupation: _____
Phone numbers (Home): (____)____-____ Work: (____)____-____ Cell: (____)____-____

3) Insurance Information (If information is the same as above, write "same"):

Policyholder's name: _____ Date of birth: ____/____/____
Policyholder's SSN: ____-____-____ Relationship to Patient: _____
Home address: _____ City _____ St. _____ Zip _____
Phone numbers (Home): (____)____-____ Work: (____)____-____ Cell: (____)____-____

4) Emergency Contact (Most people choose to list nearest neighbor):

In case of an emergency, name and telephone number of contact person not living with you:

Name: _____ Telephone: (____)____-____

5) Privacy Act and Related Information (be sure to include spouse, if desired)

I have received a copy of the Privacy Act of Physical Express, LLC, and I understand that the providers and staff of Physical Express, LLC will not discuss my health information with my family, friends, or other non-authorized persons unless I expressly authorize them to do so. I authorize the staff of Physical Express, LLC to convey information about my health to the following individual(s):

Name: _____ Relationship: _____
Name: _____ Relationship: _____

6) Contacting you regarding medical information

Physical Express, LLC may call your home or cellular telephone with information regarding your lab tests, prescription, medication or scheduled appointments for referrals. If you have caller ID, our telephone number will register. Please check mark your preferences.

Call my home and leave a message: _____ Call my cell and leave a message: _____
Call my home, but do NOT leave a message: _____ Call my cell, but do NOT leave a message: _____

By signing below, I certify that the information that I have provided is complete and correct. I further certify that I agree with the information as stated above and have had the opportunity to ask any questions with my questions having been answered to my complete satisfaction.

Print Name of Patient/Responsible Party

Signature of Patient/Responsible Party

Date