

# 2011 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