



**Patient Information**

Patient Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Patient Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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

Email: \_\_\_\_\_ Text / Email Reminders:  Yes  No

Preferred Method of Contact:  Email  Text Message  Phone Call  Other \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex:  Male  Female Status:  Married  Single  Child  Other

Employer Name: \_\_\_\_\_ Work #: \_\_\_\_\_

**Insurance Policy Holder's Information**

Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Employer: \_\_\_\_\_ Work #: \_\_\_\_\_

If patient is under the age of 18, this section must be completed.

Parent / Guardian: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Parent / Guardian Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent / Guardian Employer: \_\_\_\_\_ Work #: \_\_\_\_\_

**Patient Communication Form**

A. Family and Friends. It is the office policy of BoozmanHof not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances, (iv) in emergency situations, (v) or as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers/babysitters, please indicate that below. If you do not want any of your medical information provided to a family member, please check the "NO" box next to the corresponding line. By signing below, you authorize the following people to receive information regarding your treatment or care.

Contact Type and Name	Phone Number	Release Information?	Emergency Contact?
Spouse:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes
Parent:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes
Friend:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes
Neighbor:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes
Other:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes

Name (please print): \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient / Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_