GourleyAllergy

PATIENT INFORMATION:

Patient's name First Middle Last Date

Gender Date of Birth Marital Status Age SS#

Address City State Zip

Preferred Phone Alternate Phone Employer

Spouse Name Phone DOB

Referring Physician How did you hear about us?

Please list other household members being seen at this office

RESPONSIBLE PARTY INFORMATION: Same as above

Name Date of Birth Sex

Address City State Zip

Phone Number Relationship to patient

EMERGENCY CONTACT:

Name Phone Relationship

INSURANCE INFORMATION:

Primary Insurance	Secondary Insurance
Policy Holder	Policy Holder
Member ID #	Member ID #
Policy Holder Birthdate	Policy Holder Birthdate
Policy Holder Address	Policy Holder Address
Prescription Benefit ID#	Prescription Benefit ID#
Relationship to Patient	Relationship to Patient

Consent to Treat and to Disclose Protected Health Information: I authorize the physician or physicians in charge of the care of the above named patient to administer anesthetics and/or medications and to perform such operations and/or diagnostic procedures as may be deemed necessary by the physician for the diagnosis and treatment of this patient.
The practice's Written Privacy Notice provides detailed information on how we may use and disclose protected health information. By signing this consent form, you acknowledge that you have received a copy of the Written Privacy Notice and are in agreement with our use and disclosure of protected health information for treatment, payment, and health care operations. Patients injured at work typically obtain information through their adjuster or employer.
I have read and understand the above statements. Affixing my signature to this form represents my receipt of the Written Privacy notice, my consent to treatment, and the above listed uses of protected health information.

Signature of patient or responsible party *Date*