1911 Forest Hill Blvd, West Palm Beach, FL 33406 ☎ (561)-439-7400 🖷 (561)-439-7443 🖂 juanageldresdds@live.com

PATIENT INFORMATION

Patient's Name: ____ Date ____________________

Address: ____________________________________City: ______________________State: ______ Zip Code: _____________

Sex: **F M** Marital Status: **Single Married Widow Divorced** SS# ____________________ DOB:_________________

Work Phone: _________________________ Cell Phone: ____________________ Home Phone: _______________________

Email: ____@____

INFORMATION OF RESPONSIBLE PERSON

If any other than the Patient: Relationship to Minor/Patient:____

Patient's Name: ____ Date ____________________

Address: ___________________________________City: _____________________ State: ______ Zip Code: ______________

SS # ____________________________________ DOB: ______________________ Cell Phone: ________________________

HOW DID YOU FIND OUT ABOUT OUR OFFICE?

Patient Friend Yellow Pages Radio Website Other

HIPPA

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
CONSENT TO LEAVE MESSAGE

I, _____________________________, have received a copy of this office's Notice of Privacy Practices.

Patient's Signature ____Date: _______________________

If you are a legal representative of the patient, please print the patient's name and describe your authority________________
____. You may request a copy of our Notice at any time.

We must disclose your health information to you, and we may disclose to a family member, friend or other person to extent necessary to help with your healthcare or payment for your healthcare, but only if you agree that we may do so.

I wish to be called at home ___; Cell Phone ___; Other ___ (Check all that apply) regarding my care and follow up. The best number to reach me are: _______________________ Home _______________________Other

I do ___, I do not ___ give permission to leave relevant medical information on my answering machine or voice mail. The name(s) of the individual(s) with whom you may leave pertinent information are: ____________________________________
____

I do __, I do not __ want relevant medical information shared with the person who may answer the phone. The name(s) of the individual(s) with whom you may leave pertinent information are: ____
____

Patient's Signature ____Date: _______________________

Office use ONLY – As privacy officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

____ It was an emergency treatment ____ I could not communicate with the patient. ____ The patient refuses to sign.
____ The patient was unable to sign because: ____
____ Other

Signature of Private Officer: ____