FAMILY MEDICINE, INC.

NEW PATIENT INFORMATION

NAME: _____
ADDRESS ONE: _____
ADDRESS TWO: _____
CITY: _____
HOME PHONE: _____
WORK PHONE: _____
CELL PHONE: _____
RACE: _____
ETHNICITY: _____

DOB: _____
SOCIAL SECURITY#: _____
SEX: _____
EMAIL : _____
EMPLOYER: _____
EMERGENCY CONTACT: _____
EMERGENCY RELATIONSHIP: _____
MARTIAL STATUS: _____
PREFERRED LANGUAGE: _____

GUARANTOR INFORMATION

NAME: _____
ADDRESS ONE: _____
ADDRESS TWO: _____
CITY: _____
STATE: _____ ZIP: _____
HOME PHONE: _____
CELL PHONE: _____

DATE OF BIRTH: _____
SOCIAL SECURITY #: _____

EMPLOYER: _____
EMPLOYER ADDRESS: _____
EMPLOYER CITY: _____
STATE & ZIP: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____
CERTIFICATE#: _____
GROUP NUMBER: _____
GROUP NAME: _____
COPAY: _____
SUBSCRIBER NAME: _____

SECONDARY INSURANCE: _____
CERTIFICATE#: _____
GROUP NUMBER: _____
GROUP NAME: _____
COPAY: _____
SUBSCRIBER NAME: _____

PHARMACY INFORMATION

WHAT PHARMACY DO YOU USE?

LOCAL: (NAME AND ADDRESS)

_____
_____
_____
_____

MAILORDER (NAME)

_____

I confirm that the above information is correct to the best of my knowledge.

_____ _____
Signed (patient or parent if minor) DATE

Restriction Agreement
Release of Patient Information Consent Form

Due to federal privacy laws, we are unable to release certain personal information without your consent. If you wish for information to be released, this form must be completed, signed and returned. In your absence, you must designate a personal representative for any personal health information to be released. Please call our office if you have any questions regarding this matter.

Release information to: _____

Phone numbers: _____

Reason for release: Medical Information

Please **INITIAL** one of the following:

_____I hereby authorize Family Medicine, Inc. to provide the above-named individual or company with all medical data and information they may request, as listed below, concerning my illness or injury.

_____I hereby authorize Family Medicine, Inc. to provide the above-named individual or company with specific elements of my medical data and information, as designated below, concerning my illness or injury. Please specify the information below:

Medical Data/Information

Please initial all of the following that apply:

_____ Name, Address, Phone number
_____ Social Security number
_____ Dates of treatment
_____ Listing of diagnoses
_____ Finding of physical examination
_____ Laboratory data
_____ Reports of diagnostic testing
_____ Listing of medications
_____ Listing of treatments
_____ Information from physical consults
_____ Ancillary personal notes (check all that apply)

- ☐ Nursing
- ☐ Social Services
- ☐ Pharmacy
- ☐ Hospital
- ☐ Psychiatric Services

_____I hereby refuse Family Medicine, Inc. to provide the above-named individual or company with medical date and information concerning my illness or injury.

Signature of Patient: _____ Date: _____

Signature of Witness: _____ Date: _____

Patient's Printed Name: _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

_____, whose date of birth is _____is requesting
(Name of patient) (Date of birth)
and authorizing _____to disclose confidential healthcare information to: Family Medicine, Inc., whose address is 6525 Market Ave N, Suite 101, Canton, Ohio, 44721, phone 330-494-9785, faxes 330-494-8398 for transfer of healthcare.

I authorize records to be released as indicated below. I understand that this release is in effect until _____, but I may revoke my consent at any time by providing written revocation of consent.

Designate instructions by checking one of the following:

_____Entire medical record **including** information related to the treatment of substance abuse or dependency, psychiatric or mental health treatment; information relating to testing or treatment of sexually transmitted diseases and HIV/AIDS.

_____ Entire medical record **excluding** information related to the treatment of substance abuse or dependency, psychiatric or mental health treatment; information relating to testing or treatment of sexually transmitted diseases and HIV/AIDS.

_____Record of care from _____to _____ **including** information related to the treatment of substance abuse or dependency, psychiatric or mental health treatment; information relating to testing or treatment of sexually transmitted diseases and HIV/AIDS.

_____Record of care from _____to _____ **excluding** information related to the treatment of substance abuse or dependency, psychiatric or mental health treatment; information relating to testing or treatment of sexually transmitted diseases and HIV/AIDS.

CONDITIONS

- The patient agrees to authorize the above named individual/organization to access his/her confidential healthcare information only for the purpose listed above.
- The information authorized to be released will not be covered under federal privacy laws.
- Family Medicine, Inc. will provide the patient with a copy of the confidential healthcare information for which this authorization is being sought.
- The patient authorizes the information to be disclosed by fax transmission if necessary.
- The patient is voluntarily signing this authorization.
- The patient reserves the right to refuse to sign this authorization.
- The patient reserves the right to revoke this authorization at any time. The revocation must be presented in writing.
- This authorization will be maintained by Family Medicine, Inc. for a period of six (6) years.

SIGNATURE

Patient/Legal Representative _____Date: _____

Family Medicine, Inc. Representative _____Date:_____

Rev. 1/30/2014