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Full Name _____ Today's Date _____
Street Address _____
City _____ State _____ Zip _____
Home Phone (____) ____ - ____ Work (____) ____ - ____ Cell (____) ____ - ____
Date of Birth ____/____/____ Last 4 digits of social security number _____
Email _____
Sex ____ Male ____ Female Marital Status ____ Single ____ Married ____ Divorced

PERSON RESPONSIBLE FOR PAYMENT

Name _____ Relationship _____
Address _____
Date of Birth ____/____/____ Home Phone (____) - _____

Employment Information

Employment Status (If minor, parent's): ____ Employed ____ Student ____ Other
Employer _____ Occupation _____

EMERGENCY CONTACTS

Name _____ Phone (____) - Relation _____
Name _____ Phone (____) - Relation _____

PLEASE READ AND INITIAL

I authorize Hartwell Family Practice, PC to release any information needed by my insurance company to process my insurance claims. I also authorize payment to Hartwell Family Practice, PC for any payments otherwise payable to me. Over-payments will be refunded to the appropriate party. _____(initial)

I am aware that a finance charge of \$3.00 will be added to my account on all balances more than 30 days old _____(initial)

I have received a copy of the Hartwell Family Practice Notice of Privacy Practices _____(initial)

Patient's signature (If minor, guardian's signature)