PATIENT INFORMATION SHEET
(PLEASE PRINT CLEARLY) **DATE**_____

PATIENT'S FULL NAME_____
(First) (Middle) (Last)

ADDRESS_____
(No. & Street) (City) (State) (Zip)

HOME PHONE (____) _____WORK PHONE (____) _____CELL (____) _____

May we leave a detail voice mail? **Home**: Yes (____) No (____) **Work**: Yes (____) No (____) **Cell**: Yes (____) No (____)

E-MAIL _____ May we correspond with you via E-mail? Yes (____) No (____) Text? Yes (____) No (____)

PATIENT'S SS# _____ BIRTHDATE _____/_____/_____ AGE _____ SEX _____

MARITAL STATUS: (circle one) SINGLE MARRIED DIVORCED WIDOWED PARTNERED

EMPLOYER_____ OCCUPATION _____

BUSINESS ADDRESSS_____
(No. & Street) (City) (State) (Zip)

REFERRED BY: _____NAME OF FAMILY PHYSICIAN _____

REASON FOR TODAY'S VISIT _____

DUE TO INJURY? INJURY DATE _____/_____/_____ON THE JOB? _____ AUTOMOTIVE ACCIDENT? _____

RESPONSIBLE PARTY INFORMATION

NAME OF SPOUSE (OR PARENTS, IF PATIENT IS A MINOR) _____

SS# _____BIRTHDATE_____/_____/_____ SEX _____

EMPLOYER ____/____/_____ BUSINESS PHONE (____)_____

BUSINESS ADDRESS_____

NAME OF EMERGENCY CONTACT: _____

PHONE (____)_____ RELATIONSHIP TO PATIENT_____

NOTICE OF PRIVACY PRACTICE
I have received my copy of the privacy policy. I give my permission to disclose and discuss any information related to my medical condition(s), treatments, financial issues with the following family member(s), other relatives, and/or close personal friends:

Name: _____ Relationship: _____ Phone: (____)_____

Name: _____ Relationship: _____ Phone: (____)_____

You must inform our office, in writing, of any changes in your directive. This consent takes effect on the date below.

ASSIGNMENT OF BENEFITS:
I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including private insurance and any other health plans, to Fadi C. Constantine, M.D., PA. I transfer my title of reimbursement from my insurance company to Fadi C. Constantine. M.D., PA. I hereby agree to pay any and all charges that exceed or that are not covered by insurance. I hereby authorize said assignee to release all information necessary to secure payment. I authorize my insurance claim to be sent via electronic claim filing. I authorize the release of my medical records or insurance claims to be sent via fax. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

I have read and understand the above information regarding the privacy policy and assignment of benefits.

SIGNATURE _____ DATE _____