

MEDAC CORPORATE HEALTH

4402 Shipyard Boulevard
Wilmington, NC 28403
910-452-7000

| Today's Date | | PATIENT INFORMATION <i>This Form Must Be Completed Annually</i> | | Method of Payment | | | |
|--|---|--|------------------|---|---|---------------|----------------|
| Patient Information | Last Name | | First Name | | Middle Name | Primary Phone | |
| | Street Address | | Apt # | City | | State | Zip |
| | Permanent Address | | Apt # | City | | State | Zip |
| | Social Security Number | | Birth Date | Sex | Marital Status | | |
| | | | | <input type="checkbox"/> Female <input type="checkbox"/> Male | <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed | | |
| | Employer | | Address | | | | Business Phone |
| | Emergency Contact Name | | Address | | Primary Phone | Other Phone | |
| | E-mail Address | | E-mail Address 2 | | | | |
| Do you give permission for Medac to leave a medical message on your primary phone number or ask that you return a call to our office? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| Responsible Party <small>(if patient is younger than 18)</small> | Last Name | | First Name | | Middle Name | | |
| | Street Address | | Apt # | City | | State | Zip |
| | Social Security Number | | Birth Date | Relationship to Patient | | | |
| | Employer | | Address | | Business Phone | | |
| Accident Information | If your condition is related to an accident: | | | | Is the accident: | | |
| | Date | N/A | Time | <input type="checkbox"/> am <input type="checkbox"/> pm | <input type="checkbox"/> auto related <input type="checkbox"/> work related | | |
| HIPAA Authorization Acknowledgement and Consent | I acknowledge that I have received or been offered a copy of Medac's Notice of Information Practice (effective date September 23, 2013). I hereby authorize Medac to release to the below listed individuals, upon their request and without further authorization from me, information concerning treatments the above listed patient receives as a patient of Medac and copies of any and all medical records. This authorization is made at my request and will not expire unless revoked by me. I understand that I may revoke or restrict at any time the right of any of these individuals to receive this medical information by providing said revocation or restriction to Medac in writing. I understand that Medac will not condition treatment upon whether I authorize these individuals to receive this information. I understand that any health information and medical records disclosed to the below listed individuals may possibly be re-disclosed by them without any restrictions under federal or state privacy regulations. | | | | | | |
| | Name | | | Name | | | |
| | Relationship | | | Relationship | | | |
| Patient Consent | I HAVE READ, OR HAVE HAD EACH OF THE SECTIONS READ TO ME, AND ALL OF MY QUESTIONS HAVE BEEN ANSWERED. By affixing my signature below, I affirm that I am the patient or I am authorized to act on behalf of the patient to sign this document verifying consent to the Terms of Receipt of medical care or treatment stated on the back of this Patient Information Form. | | | | | | |
| | Signed | | Date | | Time | | |
| | (Patient) | | | | | | |
| | Signed | | Date | | Time | | |
| | (Patient's Guarantor) | | | | | | |
| Relationship to Patient | | | | | | | |
| Reason patient could not sign for him/herself | | | | | | | |
| Witness | | | | | | | |
| Date | | | | | | | |
| Time | | | | | | | |