MEDAC CORPORATE HEALTH

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

Today's Date | **PATIENT INFORMATION** *This Form Must Be Completed Annually* | 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
		☐ Female ☐ Male	☐ Single ☐ Married ☐ Divorced ☐ 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? ☐Yes ☐No

Responsible Party (if patient is younger than 18)

Last Name	First Name	Middle Name

Street Address	Apt #	City	State	Zip

Social Security Number	Birth Date	Relationship to Patient

Employer	Address	Business Phone
T. A. Woods Company	6713 Netherlands Dr.	9104527900

Accident Information

If your condition is related to an accident:
Date N/A Time ☐am ☐pm
Is the accident: ☐ auto related ☐ work related
Specifics of accident

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 _____