Fal River Health Center LLC

PATIENT DEMOGRAPHICS

First Name: ________________________ MI: ______ Last Name: ____

D.O.B: ______________ Gender: ______ E-Mail: ____

Phone: (c) (______) ___________________ (w) (______) ____________________ (h) (______) ____________________

Address: _________________________________ City: ___________________________ State: _____ Zip: ___________

Primary Care Physician: _______________________________________ Phone: (_______) ____________________

Address: _________________________________ City: ___________________________ State: _____ Zip: ___________

Emergency Contact: ____

Phone: (_______) ___________________ Relation to patient: ____

IF PATIENT IS A MINOR

Parent /Guardian's Name: ____ Relation: ___________________

Phone: (c) (______) ___________________ (w) (______) ____________________ (h) (______) ____________________

Address: _________________________________ City: ___________________________ State: _____ Zip: ___________

E-Mail: ____

***Patient / Guardian Signature**: ____

Date: ____________________________

HIPAA AGREEMENT

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge **that Fal River Health Center LLC** has given you a copy of its Notice of Privacy Practices for your perusal (and a copy of the document if you so desire). This notice explains how your personal health information (PHI) will be handled. HIPAA, the new Federal law concerning medical privacy requires this notice.

By signing below, I agree that I have read a copy of the Notice of Privacy Practices, and that this office has given me the opportunity to ask any questions about this notice and all of my questions have been answered.

Date: ____________________ Patient Name (print): ____

Patient /Guardian Signature: ____ Relation: ____________________