Patient Information Form

COPPOLA MEDICAL ASSOCIATES

Name:_____ Date of Birth: _____ Age: _____

Social Security Number: _____

City | State | Zip Code: _____

Home Phone:_____Work Phone:_____Cell Phone _____

Do we have permission to leave messages on your answering machine at home, work or on your cell phone(s).

_____

Do we have permission to release any of your medical information to anyone (ex. spouse,, children, friend etc.)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

In the event of an emergency, please contact:

Name: _____ Relationship:_____ Phone: _____

Please check all that apply:

❏ Coppola Medical Associates, Ltd. has made their patient privacy policies available for me to read.

❏ I give Coppola Medical Associates, Ltd. permission to use my protected health information for purposes of treatment, payment, and health care operations

❏ I am free to revoke this authorization at any time in writing.

_____

Signed Date