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Patient Demographics, Consent to Leave a Message and Health Care Proxy

This is a patient instruction form to the practice for handling your important medical information.
This form is revocable at patient request in writing at any time.

PATIENT NAME ____ **DATE OF BIRTH:** _____________________

ADDRESS: ____**CITY**___________________________**STATE**______**ZIP**_________

SOCIAL SECURITY NUMBER: ______________________________ **SEX:** (circle one) FEMALE MALE **GENDER:** _________________

MARITAL STATUS: (circle one) SINGLE MARRIED DIVORCED WIDOWED OTHER STATUS ________________________

ETHNICITY: (circle one) HISPANIC or LATINO NOT HISPANIC or LATINO UNKNOWN **PREFERRED LANGUAGE:** ______________

RACE: (circle one) AFRICAN AMERICAN AMERICAN INDIAN ALASKA NATIVE ASIAN BLACK
NATIVE HAWAIIAN OTHER PACIFIC ISLANDER WHITE OTHER RACE _________________________________

The best email and telephone number(s) to reach me: Email ____

Home # _________________________________ Cell/ Other # ______________________________________

Regarding my care and follow-up I wish to be called at (check all that apply) home_____ cell/other_____

I DO___, or I DO NOT___ give permission to leave relevant medical information on my answering machine or voicemail.

I DO___, or I DO NOT___ want relevant medical information shared with the person who may answer the telephone numbers noted above.

The name(s) of the individual(s) below are listed as my emergency contact, spouse or caregiver with instructions to share my relevant medical information with them or they are designated as my health care proxy:

			Share Info	Health Proxy
Emergency Contact __________________________	Phone ____________________	Relationship _________	Y or N	Y or N
Spouse ____________________________________	Phone ____________________	Relationship _________	Y or N	Y or N
Caregiver __________________________________	Phone ____________________	Relationship _________	Y or N	Y or N

Primary Care MD Group ____ Physician name __________________________

Referred by ____

Patient Signature ____ Date ____________________