



Patient Information

Patient Name:

SSN:

Date of Birth:

Evening Phone/Home #:

Daytime Phone #: (please check 'Same' if as above) **Same**

Cell Phone #: (please check 'Same' if as above) **Same**

Sex (please check): **F** **M**

Address: *Street/PO Box:*

Apt/Suite:

City:

State:

Zip Code:

Marital Status (please circle): **S** **M** **D** **W**

Signature of Patient: _____

Date:

Reason for visit:

How did you hear of us? (please check one) **Billboard** **Doctor Referral** **Friend**
 Internet **Mailer** **Newspaper** **Phone Book** **Relative** **Work** **Other**

Surya Immediate Medical Care, P.C.
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Latham, New York 12110

PATIENT PRIVACY NOTICE

Surya Immediate Medical Care, P.C. is obligated under HIPAA to protect the privacy of your Protected Health Information ("PHI") and to provide you with a notice of its privacy practice (the "Privacy Notice").

I have been informed of HIPAA regulation policy and procedures related to this at Surya Immediate Medical Care, P.C. and acknowledge that I have received a copy of the Practice's Privacy Notice.

Patient Signature

Date

(Optional) I designate _____, to act as my Designated Individual. I am aware that I can change my designated individual at any time.