Patient Information Sheet

Name: ____ **Date of Birth:** _______________

Address: ____

City: _________________________ **State:** _____________ **Zip Code:** ______________

**Your insurance requires you to let us know if your visit is accident related (i.e.: auto accident, workers compensation, etc.)

ACKNOWLEDGEMENT OF PRIVACY PRACTICE NOTICE AND DESIGNATION OF DISCLOSURE FORM

1. **Acknowledgement of Privacy Practice Notice:** I have received a copy of The Office of Edred V. Shen, MD: Notice of Privacy Practices.

2. **I wish to be contacted in the following manner. Please check all that apply:**

Home Telephone: ________________________

- ☐ OK to leave a message with detailed information
- ☐ Leave message with Name and call back number only

****Please choose one only**

Cell Phone: ____________________________

- ☐ OK to leave a message with detailed information
- ☐ Leave message with Name and call back number only

****Please choose one only**

Work Phone Number: ______________________

- ☐ OK to leave a message with detailed information
- ☐ Leave message with Name and call back number only

****Please choose one only**

Email Address: ____

- ☐ OK to email to this email address

Written Communication

- ☐ OK to mail to my home

Fax #: ___________________

- ☐ OK to fax to this number

I have filled out this form honestly to the best to my ability.

____
Name (Please Print)

_________________________________ _______________________________
Signature of Patient/Parent/Guardian Date