Practice Fusion

Entered By:_____

Date:_____

2014

Patient Information

Lytec

Entered By:_____

Date:_____

Patient Name:_____ Date of Birth: _____/_____/_____ Gender: M / F

Address: _____ Apt,Suite,Unit#:_____

City: _____ State:_____ ZIP:_____

Home#:(_____)_____-_____Work#:(_____)_____-_____Cell#:(_____)_____-_____

Occupation: _____ Referred By:_____

Email:_____ Marital Status: Single / Married / Divorced / Widowed

Are you currently covered by health insurance? **Yes / No**

Insurance Company:_____

Subscriber/Policy ID#:_____ Group#:_____

Are you the Primary Insured, Policy Holder? **Yes / No**

(If you answered No; please fill out the Policy Holder's information)

Policyholder's Name:_____ Policy Holder's Date of Birth: _____/_____/_____

******PLEASE ALLOW OUR STAFF TO MAKE A COPY OF YOUR DRIVERS LICENSE & INSURANCE CARD******

Release of Medical Information

I _____, give permission for my protected health information to be disclosed for purposes of communicating results, findings, and care decisions to the family members listed below.

Name of Authorized Individuals	Relationship to Patient	Date of Birth
_____	_____	___/___/____
_____	_____	___/___/____
_____	_____	___/___/____

_____ _____ ____/____/_____

Printed Name Signature Date