Weston Primary Care

Concierge Internal Medicine

PATIENT LEGAL NAME ____
(LAST) (FIRST) (MIDDLE)

ADDRESS: STREET ____

CITY: ______________________ STATE: __________ ZIP: ____________

HOME PHONE: ____________ WORK PHONE: ____________ CELL PHONE: ____________

BIRTHDATE: ____________ AGE: ______ SEX: ___ MARITAL STATUS: ____________

LANGUAGE: ____________ RACE: ____________ ETHNICITY: ____________

EMAIL ADDRESS: ____

PHARMACY NAME: ______________________ PHONE: ____________

INSURANCE: ______________________ ID# ____________

SECONDARY: ______________________ ID# ____________

EMPLOYER: ______________________ OCCUPATION: ____________

SPOUSE NAME: ______________________ DATE OF BIRTH: ____________

SPOUSE EMPLOYER: ______________________ WORK PHONE: ____________

EMERGENCY CONTACT INFORMATION:

Name: ______________ Relationship ____________ Phone # ____________

PATIENT NAME:____
(PLEASE PRINT)

AUTHORIZATION TO RELEASE INFORMATION
I hereby authorize the physician to release any information acquired in the course of my treatment to specific insurance company, third party payers or others involved in processing and collecting of this data.

Signature____Date:_________________

ACKNOWLEDGEMENT OF PRIVACY PRACTICES:
I hereby acknowledge that I have been informed about the Notice of Privacy Practices at Weston Primary Care, PC and have been given the opportunity to review it.

Signature____Date:_______________