Name: _____
(First) (M.I) (Last)

Address: _____

City: _____ **State:** _____ **Zip:** _____

Date of Birth: _____/_____/_____ **Sex: ( )** Male **( )** Female

SSN#: _____-_____-_____ **Marital Status: ( )** S **( )** M **( )** D **( )** W

Language Preference if not English: _____

Race: _____ (Black/African American, White, Asian, Pacific Islander, Declined)

Ethnicity: Do you consider yourself Hispanic or Latino: **( )** Yes **( )** No **( )** Declined

Emergency Contact:

Spouse: _____ Phone #: _____
(or someone who lives in your home)

Other(s):_____ Phone #: _____
(children/siblings ***someone who does not live in your home)

May we discuss your medical condition with your emergency contact(s)? **( )** Yes **( )** No

<u>Communication Methods</u>: * check all that apply

( ) Preferred Daytime Phone **#:** _____
( ) Evening Phone **#:** _____
( ) Cell Phone **#:** _____
( ) Other**:** _____

( ) May leave message to return call
( ) Ok to leave detailed message
( ) Not ok to leave message
( ) Patient Portal **coming soon
( ) E-mail **coming soon

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Release of Information:

( ) I authorize the staff of HKS to release information and/or discuss my care with the following person(s).

( ) Spouse/Significant other: _____

( ) Child(ren): _____

_____

( ) Sibling(s): _____

( ) Other: _____

This **Release of Information** will remain in effect until terminated by me in writing.

**By signing this I understand that only the persons listed above are authorized to discuss my medical care.

Anyone requesting to discuss my medical care that is NOT listed above will be refused.

** If you have a designated **POA** (Power of Attorney), please provide documentation.

Who is your Family Doctor: _____

Please list any other Specialists that you see:

1. (name)_____ (group)_____

2. (name)_____ (group)_____

3. (name)_____ (group)_____

4. (name)_____ (group)_____

Signature: _____ Date: _____