WESTSIDE MEDICAL CLINIC

PATIENT INFORMATION

NAME: _____ DATE OF BIRTH: ____/____/____
Last First Middle Initial MM / DD / YY

SEX: ☐ M ☐ F MARITAL STATUS: ☐SINGLE ☐MARRIED ☐DIVORCED ☐PARTNER ☐WIDOWED ☐OTHER

ADDRESS: _____ APT. # _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: (_____) _____- _____ MOBILE PHONE: (_____) _____ - _____

WORK PHONE: (_____) _____- _____ Ext: _____ **EMAIL ADDRESS**: _____

EMERGENCY CONTACT:

NAME: _____ RELATIONSHIP: _____ PHONE: _____

Race: ☐American Indian/Alaska Native ☐Asian ☐Native Hawaiian ☐Black/African American ☐White ☐Hispanic ☐ Other

Ethnicity: ☐Hispanic ☐Non-Hispanic ☐Refused to Report

Primary Language: ☐English ☐Spanish ☐Urdu ☐Russian ☐Other _____

Advance Directive: ☐**YES** ☐**NO** (Legal documents that allow you to convey your decisions about end-of-life care ahead of time, also known as living will)

_____

_

Pharmacy Name: _____ **Pharmacy phone number** _____-_____-_____ **or Intersection** ↓

Mail Order Pharmacy Name: _____ _____

INSURANCE SUBSCRIBER ☐ **SELF** ☐ **SPOUSE** ☐ **PARENT** ☐ **SELF PAY**
☐**WORKERS COMPENSATION** ☐ **OTHER** _____

(IF YOU ARE THE SUBSCRIBER SKIP THIS SECTION)

NAME: _____ DATE OF BIRTH: ____/____/____
Last First Middle Initial MM / DD / YY

SSN: _____ / _____ / _____ SEX: M: ☐ F: ☐ EMPLOYER: _____

PRIMARY INSURANCE

INSURANCE CO. NAME _____ PLAN TYPE: HMO / PPO / POS ☐ Other: _____

MEMBER ID # _____ GROUP #_____

SECONDARY INSURANCE: ☐**YES** ☐**NO** **If YES Name:** _____

I authorize Syed V. Ahmed, M.D., P.A. and his staff at Westside Medical Clinic to release any information obtained in the course of my treatment to my insurance company, employer, or third party payer, governmental agency as required for filing claims, quality assurance, health plan administration, public health and complains follow-up. I authorize direct payment to be made to Syed V. Ahmed, M.D., P.A. for any and all medical services provided. **I understand that if any services or charges are not covered I will be responsible for all charges incurred. I have received and understand the Notice of Privacy Practices.**

PATIENT/GUARANTOR SIGNATURE: _____ DATE: _____

Rev. 02/27/2015

Designation for Release of Medical Information to a Family Member, Friend Or Legal Representative

Introduction

It is the physicians' responsibility to ensure that the physician-patient relationship is confidential. The Health Portability and Accountability Act (HIPPA) allows physicians to use their professional judgment on disclosing certain personal health information to family, friends, etc. without an authorization. This form is an aid to the physicians in making a determination on disclosing such information. Westside Medical Clinic realizes that there are times when you, the patient, may want another person to be knowledgeable about your medical condition or medical needs. Your doctor wants you to be able, if you so desire, to name a person to whom you want the office staff to speak with about your medical condition. To enable that, we would ask that you complete the form listed below. Please note the following points:

- Only one person can be designated for this role
- The designation is valid until you cancel it in writing
- If you designate no one, Westside Medical Clinic will not release information to any family member or friend or legal representative.

Designation Statement

I, _____, designate the following person (s) to be able to speak to a physician at Westside Medical Clinic, or other staff member, should it be necessary, on my behalf. I hereby give permission to Westside Medical Clinic through its physicians and staff to release to my designee any information about my medical condition or medical needs or the status of my account and I release Westside Medical Clinic its physicians and staff, from any claim of confidentiality in connections with the release of this information.

☐ **I accept to designate another person to speak with my physician or clinical staff**

(1) **Name of Designated Person**: _____

Relationship: _____ Phone Number _____ (Home/Work/Cell)

(2) **Name of Designated Person**: _____

Relationship: _____ Phone Number _____ (Home/Work/Cell)

(3) **Name of Designated Person**: _____

Relationship:_____ Phone Number _____ (Home/Work/Cell)

Patient's Signature: _____ Date: _____

Witness: _____

☐ **I decline to designate another person to speak with my physician or clinical staff.**

Patient's Signature: _____Date: _____

Witness: _____