advocare | Center for Specialized Gynecology

Updated Demographic Form

Patient Last Name:_____ First Name: _____ DOB:_____

Address:_____ City, State: _____Zip:_____

Preferred Phone Number (For Appointment Reminders): (_____)_____ [ ] Home [ ] Cell
Preferred Phone Number (For Results): (_____)_____ [ ] Home [ ] Cell

E-Mail Address (this is MANDATORY for communication with your doctor) _____@_____.com

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Primary Care Physician

Dr. _____

Address_____

Phone #_____

Referring Physician

Dr._____

Address_____

Phone #_____

****

Primary Insurance:_____

ID # _____

Group #_____

Secondary Insurance: _____

ID #_____

Group #_____

We are required by law to maintain the privacy of protected health information, and provide individuals with this Notice of our legal duties and privacy practices with respect to protected health information.
Please sign below to acknowledgement that you have been afforded an opportunity to review this Notice of our Privacy Practices in accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, I understand that:
1. I may revoke this authorization at any time, except to the extent where action has already been taken in accordance to the original authorization for disclosure. My revocation must be in writing, signed by me or on my behalf, and delivered to your office address.
2. A copy of this authorization may be used with the same effectiveness as the original. This authorization replaces any prior written authorization I have made regarding the use, release, and disclosure of my medical information.

I authorize messages w/ medical information to be left on voicemail at (check all that apply):
□Home #_____ □ Cell #_____ □ Work #_____

Release of Information
I authorize the following individual(s) to receive information pertaining to any medical history and treatment:
Name: _____Relationship: _____ Ph: _____

I authorize the following individual(s) to receive information pertaining to any billing issues:
Name: _____Relationship: _____Ph: _____

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Local Pharmacy

Name: _____

Address: _____

Phone #: _____

Signature: _____

Mail-Away Pharmacy

Name: _____

Address: _____

Phone #: _____

Today's Date: _____/_____/_____