

Personal Information

Your Name: _____ Birthdate: _____ Date: _____

Address: _____ Apt: _____ City: _____ State: _____ Zip: _____

Marital Status: _____ Race: _____ Ethnicity: Latin/Hispanic Other Prefer not to list

Home Phone: _____ SS# _____

Fax: _____ Work Phone: _____ Cell Phone: _____

Best way to reach you: Home Cell Work

Referring Physician: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Care Physician _____ Phone: _____

Spouse: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____ hm / cell / wk

* Emergency Contact _____ Relation: _____ Phone: _____ hm / cell / wk

Patient's Employer: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

PRIMARY INSURANCE

Please circle if appropriate: HMO / PPO

Insurance: _____

Insured Name: _____

Phone: _____

Relationship: _____

Policy #: _____

Insured DOB: _____ SS#: _____

Group #: _____

Insured's Address: _____

Insured Employer: _____

Employer Address: _____

SECONDARY INSURANCE

Please circle if appropriate: HMO / PPO

Insurance: _____

Insured Name: _____

Phone: _____

Relationship: _____

Policy #: _____

Insured DOB: _____ SS#: _____

Group #: _____

Insured's Address: _____

Insured Employer: _____

Employer Address: _____

**NORTH TEXAS INFECTIOUS DISEASES CONSULTANTS, PA Patient
Consent for Use and Disclosure of Protected Health Information**

North Texas Infectious Diseases Consultants, PA, (NTIDC) may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to NTIDC's Notice of Privacy Practice for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Procedures prior to signing the consent. NTIDC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the NTIDC Privacy Officer at 3409 Worth St, Suite 710, Dallas, Texas, 75246.

You may disclose protected health information (PHI) about me to the people listed below. (You must include full name.)

1. _____ 2. _____ 3. _____

With my consent, NTIDC may email me, any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements. I have the right to request that NTIDC restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement

Email Address: _____ **N/A**

This office uses LabCorp. If your insurance requires that you use a different lab you must let the office know. My insurance prefers: (circle one)

LabCorp Quest Unknown (If unknown you must call your insurance to check)

With my consent, NTIDC may contact me regarding a possible research study.

Initials _____

By signing this form, I consent to NTIDC's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance to prior consent.

Print Patient's Name

Date of Birth

Patient's Signature

Date

Signature of Patient's Legal Guardian

Print Name of Patient's Legal Guardian