SYLVAN LAKES FAMILY PHYSICIANS, LTD
7640 W. SYLVANIA
SYLVANIA, OHIO 43560
419-517-1001

PATIENT INFORMATION

NAME: _____SOCIAL SECURITY# _____

DATE OF BIRTH: ____/___/___ AGE: ____ SEX F ___ M___

MARITAL STATUS: S___ M___ W ___ D ___

PRIMARY LANGUAGE: _____

ETHNIC BACKGROUND: ___ CAUCASIAN___ AFRICIAN AMERICAN___ HISPANIC
___ AMERICAN INDIAN___ NATIVE HAWAIIAN___ASIAN
___ OTHER: _____
____ REFUSE TO REPORT

ADDRESS _____

CITY, STATE AND ZIP _____

HOME PHONE _____ CELL PHONE _____

WORK PHONE _____

MAY WE LEAVE A DETAILED MESSAGE ON YOUR ANSWERING MACHINE OR YOUR VOICEMAIL? YES ___ N ___

EMERGENCY CONTACT: _____REALTIONSHIP: _____ PHONE: _____

RELEASE OF INFORMATION AND BENEFIT ASSIGNMENT

Often it is difficult to reach a patient to convey physician orders or test results. In this event, with your signed authorization, we would release such information to a person you designate. Please complete the section below.

I authorize Sylvan Lakes Family Physician to release any information in the course of my examination or treatment to the following designate person (s):

NAME: _____PHONE NUMBER _____

NAME: _____PHONE NUMBER _____

Signature: _____Date: _____

I hereby give permission to Sylvan Lakes Family Physicians to exam and treat me. I also assign, transfer and set over to Sylvan Lakes Family Physicians and their physicians all of the medical reimbursement benefits under my insurance policy. I also authorize the release of any medical information and records needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorizations. I understand that I am financially responsible for all charges and I agree to promptly pay all charges when billed and accept legal responsibility for any and all charges for the patient named.

Signature: _____ Date: _____

I herby acknowledge that I have received notification in writing about HIPAA Privacy Rules.

Signature: _____ Date: _____