BURKE PRIMARY CARE
FAMILY PRACTICE

Date________

Last Name_____ First Name_____ MI____

Date of Birth_____ Sex: M / F Social Security #_____

Address_____ City_____ State_____ Zip_____

Mailing Address (if different) _____

[ ]Home Phone_____ [ ]Work Phone_____ [ ]Cell Phone_____

Email_____
Communication Preference: [ ] Phone [ ] Mail [ ] Portal

Occupation_____ Employer/School_____ [ ]Retired [ ]Student

Preferred Pharmacy_____

Preferred Language_____ Other Languages Spoken_____

Race: [ ] White [ ] Black [ ] Asian [ ] Hawaiian [ ] Indian/Alaskan [ ] Pacific Isle [ ] Other/Multi
Ethnicity: [ ] Non-Hispanic [ ] Hispanic
Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Separated [ ] Widowed

Emergency Contact_____ Phone_____ Relationship_____

Primary Insurance_____ ID#_____

Policy Holder Name (if different from patient) _____ Relationship_____

Policy Holder's Birth date_____ Policy Holder's SS#_____

Other Family Members in Household (if applicable):

Spouse Name_____

Parent's Names_____

Children_____

Siblings _____

Authorization for Release of Medical Information

Patient_____ Birth Date_____

I acknowledge that I have received a copy of the Notice of Privacy Practices. I understand that I may amend or revoke these authorizations at any time by submitting a signed and dated notice. This authorization will remain valid unless I revise and sign a new form. I authorize the release of medical information to and from other physicians or medical facilities in order to effectively manage my medical care. Please circle **YES or NO**:

♦Voicemail Messages: I give permission for the office to call any of the following numbers and leave a voicemail message with appointment information, test results, referrals, recommendations and other messages.
Home #_____ Work #_____ Cell #_____ circle **YES / NO**
♦Mail: I give permission for the office to mail correspondence including diagnostic test results, scheduling reminders, and other information regarding my health care to my mailing address. **YES / NO**
♦Authorized Contacts: I give permission for the office staff to speak with the following individuals regarding my healthcare:

[ ] NONE, only myself

Name/Phone #_____
Name/Phone #_____

♦Discretionary Disclosure: I choose to leave decisions regarding the disclosure of my health care information to the discretion of Burke Primary Care and their staff, believing that they maintain the best interest of my health and medical well-being. YES / NO

Acknowledgment of Financial Responsibility
♦I authorize the release of medical and other information necessary to process medical claims. I authorize payment of insurance claims be made to the physician.
♦I assume responsibility for payment of medical services that are not a covered benefit of my insurance. Covered benefits may be verified by contacting the Customer Service Department of the insurance.
♦I assume responsibility for charges incurred if correct, current, and complete insurance information is not presented at the time of service.

Signature of Patient/Guardian_____ Date_____

If this authorization is not signed by the patient, complete the following information:
Print Personal Representative's Name_____
Relationship to Patient_____ Representative's Phone Number_____