GISD EMPLOYEE CLINIC

Authorization of use and Declaration of Protected Health Information- Must be *COMPLETELY* filled out

Patient's Name: Patient's Name Marital Status: **M D W S** (circle one)

Patient's Home address: Patient's Home Address City City Zip Zip

Home phone: Home Phone Cell phone: Cell Phone

Patient's Social Security #: Patient's Social Security Date of Birth: Date of Birth Patient: Male or Female

GISD Employee works at (school/location): School/Location **Work phone** Work Phone

GISD Employee ID # GISD Employee ID#

Patient's Employer: Patient's Employer Your Work Phone Your Work Phone

Patient's relationship to Insured Patient's Relationship to Insured

If you are filling this out for your child's appointment today, we need to know who may bring your child to their appointments when you are unavailable:

If you have an answering machine or voice mail, may we leave messages regarding appointments, treatments and or/other information pertinent to your healthcare? **(Circle One*): YES or NO***

Please let us know the BEST way to contact you? (Circle one or more): Home Cell Work

May we speak to your spouse or parents*:* ***Yes or No*** **(Circle One)**

Name of Spouse or Parents: Name of Spouse or Parents

In case of an Emergency Please provide a contact person,

****if patient is a MINOR we would like someone *other than parents* because we would automatically contact parents:**

Name: Name of Spouse or Parents

Phone: 1) Phone1 **2)** Phone2

Relationship to Patient: Relationship to Parent

NAME OF YOUR PRIMARY CARE PHYSICIAN Name of Primary Care Physician

_____ Relationship to Patient Today's Date

SIGNATURE OF PATIENT OR Authorized Person | Relationship to patient | Todays Date

Printed Name of Patient

PRINTED NAME OF **PATIENT**

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