NP F/U HF/U

Chart Ready ☐

INFECTIOUS DISEASES ASSOCIATES, P.C.
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Patient Demographics and HIPAA Agreement

Patient Name: _____
(First) (MI) (Last)

Date of Birth: _____ Social Security#: _____

Address: _____
(Street) (City) (State) (Zip)

Home Phone: _____ Cell: _____

Occupation:_____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: _____

Primary Care Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

Pharmacy Name: _____ City: _____ Street: _____

I hereby authorize payment for the surgical and/or medical benefits rendered to me to: Infectious Diseases Associates, PC. I further authorize Infectious Diseases Associates, PC to release any information required in the course of my examination or treatment to my insurance carriers and any other clinicians to whom I may be referred. I understand that I am responsible for any charges not covered by my insurances.

Sign Name: _____ Date: _____

I acknowledge receipt of the Notice of Privacy Practices (HIPAA) from Infectious Diseases Associates. A copy of the current notice is posted in the reception area.

Sign Name: _____ Date: _____