

Patient Information Form (please print legibly)

Last Name: _____ First Name: _____ MI: _____
Other names/Maiden Name: _____
Date of Birth: _____ Sex: _____ Place of Birth: _____
Address: _____ Apt: _____
City: _____ State: _____ Zip: _____
Occupation: _____ Email Address: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Parent's Name (minors only): _____
Emergency Contact: _____ Contact's Phone #: _____
Emergency Contact is my: (specify relationship) _____
Referred by: _____
Insurance Company: _____ Subscriber ID #: _____

Acknowledgement of Receipt

Dr. Salina Chan is required to provide you with a copy of her Notice of Privacy Practices and to obtain written acknowledgement, if possible, that you have received it. The notice outlines the types of uses and disclosures that may occur involving your protected health information, describes your rights and explains how you may exercise those rights. Please read it carefully. If you have questions concerning the management of your healthcare information at our clinic, wish to inquire about your rights or if you wish to schedule an appointment to view your medical record, please contact us at (206) 292-9646.

I hereby acknowledge that I have received a copy of Dr. Salina Chan's Notice of Privacy Practices.

X _____ Date _____
Patient's Signature

X _____ Date _____
Guardian/Representative's Signature

Relationship to Patient/Representative Authority

OFFICE USE ONLY

Unable to Obtain Acknowledgement

This section serves as a record of the above practitioner's good faith effort to obtain written acknowledgement of receipt from the patient for the Notice of Privacy Practices. Patient was given a copy of the notice on: _____.

Patient refused to sign acknowledgement.
 Patient is physically unable to sign acknowledgement.
 Other: _____