PATIENT INFORMATION SHEET

PATIENT

First Name: _____M.I.: ____ Last Name: _____

Address (***IF DIFFERENT ON ID)***

_____

City: _____State: _____ Zip: _____

Home Phone: (_____) _____Mobile Phone: (____) _____

Work Phone: (_____) _____

Social Security #: _____ D.O.B: _____

Sex: _____ Marital Status: _____

Employer: _____ Email: _____

Pharmacy (***Name & Address***): _____

Referring Doctor: _____Primary Doctor: _____

Name of Primary holder to insurance (***If not the patient***): _____

Date of birth: _____ Relationship: _____

EMERGENCY CONTACT

Name: _____Tel: (____) _____

Relationship to you: _____

Signature: _____ Date: _____

PLEASE TURN OVER

Dr. Jatinder Sekhon
Dr. Susan H. Barton
10110 Molecular drive, #109
Rockville, MD 20850
Tel: 301-417-9528
Fax : 301-417-9558

PERSONAL REPRESENTATIVE, FAMILY OR OTHER ENTITIES AUTHORIZED ACCESS TO PROTECTED HEALTH INFORMATION TO BE USED AND/OR DISCLOSED.

Name or specifically identify these persons and/or other entities you are authorizing to make use of and/or to disclose your protected health information regarding treatment, payment and other healthcare operations *other than yourself*.

Name of Authorized Person or Entity / Relationship/ Phone number

_____

Name of Authorized Person or Entity / Relationship/ Phone number

_____

AUTHORIZATION FOR USE OF ANSWERING MACHINE AND/OR VOICE MAIL/EMAIL ADDRESS

Dr. Sekhon/Dr. Barton and office staff routinely are unable to contact patients directly during normal business hours. On these occasions our office leave messages on communication devices provided by our patients. Due to the new federally mandated HIPAA Privacy Rule, we must obtain your authorization to continue this mode of communication.
Protected Health Care Information that we may possibly disclose on your home,work, cell phone or email address would include, but is not limited to: test/lab/biopsy results, prescription/pharmacy information, instructions for procedures and office/surgical scheduling information.

_____(Initial) Yes, I agree to allow Dr.Sekhon and staff to email messages that include protected Healthcare Information, my email address is _____.

_____(Initial) I agree to allow Dr.Sekhon and staff to leave messages that include protected Healthcare Information on any of the following: Please indicate the phone number next to the applicable communication devices.
_____home number, _____ work number _____cell number
_____(Initial) No, I do not agree to allow Dr. Sekhon and staff to leave messages that include protected healthcare information on my home,work or cellphone.

_____

Patient's Signature Date