

PATIENT INFORMATION
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DATE: ____/____/____ REFERRING PHYSICIAN/ MIDWIFE: _____

PATIENT'S NAME: _____
(FIRST) (MIDDLE) (LAST)

DOB: ____/____/____ AGE: ____ SOCIAL SECURITY #: ____-____-____

HOME PHONE: (____) ____-____ WORK :(____) ____-____ CELL :(____) ____-____

HOME ADDRESS: _____ APT. #: ____

CITY: _____ STATE: _____ ZIP CODE: _____

EMPLOYER: _____

SPOUSE/ PARTNER'S NAME:

(FIRST) (MIDDLE) (LAST)

DOB: ____/____/____ AGE: ____ SOCIAL SECURITY #: ____-____-____

EMPLOYER: _____

EMERGENCY CONTACT INFORMATION

NAME: _____ RELATIONSHIP: _____

HOME PHONE: (____) ____-____ WORK PHONE :(____) ____-____ CELL PHONE :(____) ____-____

Please provide the best contact phone numbers, at which we can contact you or leave a message regarding the following:

- Lab results
- Appointment reminders
- Changes to scheduled appointments
 - Billing information

PRIMARY #: (____) ____-____ HOME CELL WORK

ALTERNATE #: (____) ____-____ HOME CELL WORK

Joshua L. Weiss, M.D. Associated
PATIENT INFORMATION

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AUTHORIZATION TO DISCUSS PROTECTED INFORMATION

I, _____, authorize Dr. Joshua L. Weiss, M.D. to release, or discuss,
(PRINT NAME)
Any patient information related to my medical condition including: treatment plan, medications, and/or
billing information, to my insurance carrier, and my referring physician, and to the following persons listed:

1) _____ 2) _____

3) _____ 4) _____

- **PLEASE BE ADVISED:** Any person not listed on the above list, will NOT be given any information related to your care, including billing information. You may change, restrict, or expand this list at any time.
- You are not required to list any name(s) if you do not so choose.

ADVANCE DIRECTIVE/LIVING WILL

Do you have an advance directive or living will? Yes _____ No _____

If no, are you interested in receiving information pertaining to one? Yes _____ No _____

I CERTIFY THAT ALL INFORMATION PROVIDED IS TRUE AND CORRECT, TO THE BEST OF MY KNOWLEDGE.

PATIENT SIGNATURE: _____ **DATE:** ____/____/____
