PATIENT INFORMATION SHEET

Patient's Name (last)	First	Middle	Birthday

Mailing Address	City	State	Zip

Local Address (number, street or apt# if different from above)	Home Phone #

Age	Sex	Maiden Name	Marital Status	Social Security #

Spouse's Name (parent if minor)	Phone #	Date of Birth	Social Security #

Emergency Contact (not living at same address)	Relationship	Home Ph. #	Work Ph. #

Patient's Occupation (Father's if minor)	Name & Address of Employer	Supervisor's Name Date of Hire	Work Ph. #

Spouse's Occupation (Mother's if minor)	Name & Address of Employer	Supervisor's Name Date of Hire	Work Ph. #

It is the policy of our office to protect all of your private health information. There are, however, times when it may become necessary for us to discuss your treatment, post-operative treatment, appointment or billing with someone other than yourself. Please list the names below of individuals (family, "spouses", and friends) or other doctors that we may speak with (**IF THEY ARE NOT ON THIS LIST, WE CAN NOT SPEAK WITH THEM).**

NAME	RELATIONSHIP to PATIENT	PHONE NUMBER

What other ways may we contact you? From time to time we will need to leave a message for you (as stated in our Notice of Privacy Practices) on answering machine, voice mail, or with another individual in your absence. **Is it OK to leave a message that includes details (such as diagnosis, billing, medical information) at the numbers you have provided below:**

Home Number_____ Yes or No

Work Number _____ Yes or No

Cell Number _____ Yes or No

Other Number _____ Yes or No

I allow faxed/e-mailed transmittal of my medical records if necessary. Yes or No

I acknowledge and agree that I have reviewed a copy of East Tennessee Oral Maxillofacial Surgery's Notice of Privacy Practices and have completed the forms above to the best of my knowledge.

_____ _____ _____

Signature of Patient or Guardian Relationship to patient Date