PATIENT INFORMATION/PRIVACY FORM

Today' Date ________________________

Last Name _________________________ First Name _________________________ Middle Initial ________

Address____________________________ City _________________________ State ______ Zip __________

Home Telephone ____________________ Work _________________________ Cell ____________________

Email Address ____________________________ Emergency Contact/Number _________________________

Date of Birth ___________ Social Security No. ____________________ Driver's License No. _____________

Sex: M F Marital Status: Single Married Widowed

Employer ____________________________________ Occupation ___________________________________

Responsible party (if different from patient): ____

Address____________________________ City _________________________ State ______ Zip __________

Home Telephone ____________________ Work _________________________ Cell ____________________

Date of Birth _______________________________ Social Security No. _______________________________

Relation: parent guardian spouse other ____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

The law requires that Drs. Gibson, Gibson, and Moore make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

- **I have read or had explained to me Drs. Gibson, Gibson, and Moore's Notice of Privacy Practice and agree to continue my care with the doctors under said terms.**
- **I was given the opportunity to read Drs. Gibson, Gibson, and Moore's Notice of Privacy Practice and declined, but wishes to continue my care with the doctors under said terms.**
- **I have read or had explained to me Drs. Gibson, Gibson, and Moore's Notice of Privacy Practice and do not wish to continue my care with the doctors under said terms.**
- **The Notice of Privacy Practice could not be read due to other reasons described below**

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I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY

_____________________________________ _________________

Patient **Date**

If you are signing as a personal representative of the patient, please indicate your relationship

_____________________________________ ____________________________

Representative **Relationship to Patient**