MESQUITE EMPLOYEE HEALTH CENTER

Authorization of use and Declaration of Protected Health Information

Patient's Name:____ Age:____________________

Patient's Home address:_______________________________City_______________Zip_____________

Home phone: ____________________________ Cell phone: __________________________________

Patient's Social Security #:____________________ Date of Birth:____________ Patient: Male or Female

Insured's : MISD or CITY Dept /School Employed at _____________________Work phone_________

Insured's Job Title: _________________________Patient's relationship to Insured __________________

If you have an answering machine or EMAIL address, may we leave messages regarding appointments, treatments and or/other information pertinent to your healthcare? Circle One: YES or NO

Please let us know the BEST way to contact you? Circle one or more: Home Cell Work Email

If you would like us to give detailed lab results on your secure email address please provide your email below: Please print clearly to insure you receive it. If you do not have email please leave blank.

EMAIL address: ____ **MUST BE SECURED EMAIL**

May we speak to you spouse or parents: Yes or No Name of Spouse or Parents:___________________

If you are filling this out for your child's appointment today, we need to know who may bring your child to their appointments when you are unavailable:____

In case of an Emergency Please provide a contact person, if patient is a MINOR we would like someone other than parents because we would automatically contact parents:

Name:____ Phone:__________________________________

Relationship to Patient:__________________________

______________________________________ ____________________ _______________

SIGNATURE OF PATIENT OR Authorized Person Relationship to patient Todays Date